IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

Appeal No. 30494

MICHAEL ARNESON, *Claimant/Appellant,*

vs.

GR MANAGEMENT, LLC, d/b/a MINERAL PALACE CASINO,
Employer/Appellee, and

RISK ADMINISTRATION SERVICES, INC., *Insurer/Appellee.*

Appeal from the Sixth Judicial Circuit
Hughes County, South Dakota
The Honorable Christina Klinger
Circuit Court Judge

APPELLANT'S BRIEF

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES:

STATUTES:

I. PRELIMINARY STATEMENT

As used in the following brief, Michael Arneson will be referred to as Claimant or Arneson and GR Management, LLC, d/b/a Mineral Palace Casino and Risk Administration Services, Inc. will be referred to collectively as Employer and Insurer. References to the Department's record will be made using "DI" denoting the Department's Chronological Index filed with the Clerk. Testimony from the September 14, 2022, hearing before the Department will be made using "HT." References to the Circuit Court's record will be made using "CCI" denoting the Circuit Court's Chronological Index filed with the Clerk. References to Appellant's Appendix will be "App."

II. JURISDICTIONAL STATEMENT

Claimant filed a Petition for Hearing with the South Dakota Department of Labor on July 1, 2019. (DI 3-8.) Employer and Insurer filed a Joint Answer on August 8, 2019, denying that Claimant's July 2018 work injury is and remains a major contributing cause of his current nerve damage and paroxysmal atrial fibrillation injuries. (DI 11-13.) The Department held a hearing on the merits on September 14, 2022, in Rapid City, South Dakota. Administrative Law Judge Michelle Faw issued a Decision on March 21, 2023, finding that the electrical shock Claimant experienced was a major contributing cause of his condition, that he was obviously unemployable and permanently and totally disabled and entitled to benefits under the odd-lot category, and

was entitled to past disability benefits and ongoing medical and disability benefits. Judge Faw issued Findings of Fact and Conclusions of Law along with an Order dated April 28, 2023. (App. 36-67.) On May 15, 2023, Employer and Insurer appealed the Department's Decision to the Sixth Judicial Circuit. (DI 2021.)

On September 25, 2023, the Circuit Court heard oral argument. On October 6, 2023, the Honorable Judge Klinger issued a Memorandum Decision and Order reversing and remanding the Department's decision that the electrical shock Claimant experienced was a major contributing cause of his atrial fibrillation and that he was permanently and totally disabled and entitled to benefits under the odd-lot category. (App. 1.) However, the Circuit Court affirmed the Department's decision that Claimant proved his work-related injury was and remained a major contributing cause of his right-hand injury and need for medical treatment. (*Id.*) On October 18, 2023, Claimant appealed the Circuit Court's decision to this Court. (CCI 2590.)

III. STATEMENT OF THE ISSUES

1. Whether the Circuit Court erred in reversing the ALJ's determination that Claimant proved his workplace injury was a major contributing cause of his developing atrial fibrillation.

The Department held Claimant proved by a preponderance of the evidence that the electrical shock he experienced on July 18, 2018, is a major contributing cause of his condition.

The Circuit Court disagreed and found that Arneson did not meet his burden by a preponderance of the evidence that the work incident was a major contributing cause of his AFib.

- *Billman v. Clarke Mach., Inc.*, 2021 S.D. 18, 956 N.W.2d 812
- *Hughes v. Dakota Mill & Grain, Inc.*, 2021 S.D. 31, 959 N.W.2d 903
- *Orth v. Stoebner & Permann Const., Inc.*, 2006 S.D. 99, 724 N.W.2d 586
- *Mettler v. Sibco, Inc.*, 2001 S.D. 64, 628 N.W.2d 722
- SDCL 1-26-36

2. Whether the Circuit Court erred in reversing the ALJ's determination that Claimant proved he was permanently and totally disabled and was entitled to benefits under the odd-lot category.

The Department held Claimant proved he is permanently and totally disabled and made a prima facie showing of entitlement to benefits under the odd-lot category.

The Circuit Court disagreed and found that Arneson was not "obviously unemployable" or permanently and totally disabled because he voluntarily left the job market.

- *Eite v. Rapid City Area School Dist. 51-4*, 2007 S.D. 95, 739 N.W.2d 264
- SDCL 1-26-36
- SDCL 62-4-53

IV. STATEMENT OF THE CASE

Arneson was working as the maintenance manager for the Mineral Palace, when a commercial exhaust fan shorted, electrocuting Claimant and sending 300 amperes and 440 volts of electricity, into his right hand, through his heart, and out his left foot. The electrocution caused two primary injuries to Claimant: (1) permanent numbness in his right thumb, index finger, and middle finger; and (2) episodes of atrial fibrillation multiple times a day with resulting fatigue that requires Claimant to sit or stand and rest for a few minutes to a half hour at a time. As a result of his injuries and symptoms, Claimant was unable to

perform his duties for Employer and has been unable to find any other employment that could accommodate his restrictions.

The Department conducted a hearing and issued a decision fully favorable for Claimant, finding that the electrical shock was a major contributing cause of his condition and he is permanently totally disabled. Employer and Insurer appealed arguing that the Department should be reversed because Arneson failed to prove the electrical shock was a major contributing cause of his condition and the Department did not allow Employer and Insurer to rebut Claimant's prima facie showing that he was obviously unemployable. As to Employer and Insurer's causation argument, the Department agreed with, and found more credible, the medical evidence and testimony presented by Claimant. As to Employer and Insurer's right to rebuttal argument, the Department did allow Employer and Insurer to present all the evidence and arguments desired regarding positions in the community allegedly available to Arneson with his restrictions, however, the Department chose to reject those arguments and agreed with the opinions of Claimant's vocational consultant, Tom Audet.

The Circuit Court issued a Memorandum Decision reversing the Department. On issue one, the Circuit Court found that it was "persuaded" Arneson failed to establish that the electrocution event was a major contributing cause of his developing AFib. On issue two, the Circuit Court reversed the Department's determination that Arneson

proved he was "obviously unemployable or permanently and totally disable[d]" and instead found that Arneson was not "obviously unemployable" because he voluntarily left the job market and failed to return to his position with the Mineral Palace.

This Court should reverse the Circuit Court's decision because it ignored and omitted multiple factual determinations the Department found significant in finding for Claimant. It also did not explain why the Department's factual and credibility determinations were "clearly erroneous" or why it was "left with a definite and firm conviction that a mistake has been made." Instead, the Circuit Court merely substituted its opinion for that of the Department. The Circuit Court's failure to follow the appropriate standards of review renders its decision erroneous as a matter of law. As a result, the Circuit Court failed to establish the Department's determinations are clearly erroneous, not supported by substantial evidence, and that the Circuit Court was definitely and firmly convinced a mistake has been made. Accordingly, Claimant asks that the Court affirm the Department's decision that Claimant's injuries arose out of and in the course of his employment at the Mineral Palace, that those injuries are and remain a major contributing cause of his disability and need for treatment, and that Claimant is permanently totally disabled.

V. FACTUAL AND PROCEDURAL HISTORY

A. Educational Background

Claimant was born on August 24, 1955, and raised in Appleton, Wisconsin. (HT 9:2-3.) He attended high school at Appleton West High School, but quit school in 1972 to join the United States Navy. (HT at 10:1-13.) A short time later Claimant got his GED and enlisted in the Navy, however, he was only in the Navy about 45 days because of an issue with his eyesight, so he was honorably discharged. (HT 10:12-22.) Shortly thereafter he attended several six-month courses wherein he achieved degrees in electrical, plumbing, machine operator, and pool supplies. (HT 10:23-11:20.)

B. Employment History

Claimant began working shortly after he finished getting his technical degrees. Those jobs primarily consisted of machine operator, over-the-the-road trucker, engine repair, and maintenance. (HT 11:21-14:11.) On September 15, 2015, Claimant started work as the maintenance manager for the Mineral Palace in Deadwood, South Dakota. (HT 14:22-24.) His duties included: overseeing maintenance personnel, cleaners, and valet; painting, tiling, carpentry, snow removal, lawn care, and miscellaneous cleaning; servicing exhaust units, A/C units, and kitchen equipment; and also monitoring the plumbing and electrical units. (HT 114:25-16:8.)

The job duties at the Mineral Palace were "heavy duty" in that Claimant would need to carry heavy objects such as:

- five-gallon buckets of soap weighing 45-50 pounds;
- canned goods weighing 20-50 pounds;
- salt for conditioners weighing 50 pounds; and,
- motors, breakers, and wood.

(HT 17:21-19:21.) Claimant would have to perform these duties on a daily basis anywhere from 1-10 times. (HT 19:22-20:4.) Arneson also had to frequently walk up and down flights of stairs, climb up and down ladders to access the roof, and walk across the length of the Mineral Palace. (HT 20:5-19.)

C. Claimant's Worker's Compensation Injury

On July 17, 2018, there was an electrical storm in Deadwood that caused a power outage at the Mineral Palace. (HT 21:20-22:10.) That night Claimant went to the Mineral Palace and checked out the facility and its equipment. He then shut off the equipment with the plan to return in the morning to check it all out. (HT 22:11-22.)

Claimant arrived at the Mineral Palace at 6:30 the next morning to assess the damage from the electrical storm. (HT 22:23-25.) He checked the exhaust fan and shut the shunt off, which cuts the power to the fan. (HT 23:1-24:23.) After making sure that there were no shorts in the wires, he turned the breaker on and confirmed all three lines had power. (*Id.*) Claimant then went back on the roof to turn the shunt back

on. (*Id.*) When Claimant touched the shunt it shorted—electrocuting Claimant. (*Id.*)

Shortly after he was electrocuted, Arneson began to feel a tingling sensation in his right hand. (HT 25:4-13.) He pulled his glove off and saw that the electricity had burned all five fingers on his right hand. (*Id.*; DI 1632, 1633, and 1635.) Arneson then went to the Lead-Deadwood Emergency Department. (HT 29:10-14.) Claimant's primary problems at the Emergency Department were the burns to his hand and a hole in Claimant's left foot which represented where the electricity exited his body. (HT 26:4-14; DI 1634.) The records reflect that while in the Emergency Department Arneson was complaining of numbness and tingling in his fingertips. (DI 1555-60.)

Claimant continued to work at the Mineral Palace despite being electrocuted. (HT 30:9-11.) However, a few days after the incident Arneson began to feel some minor heart palpitations. (HT 29:19-30:2.) Claimant did not think anything about them at the time, but over the next few days he continued having palpitations. (HT 30:3-8.) The palpitations were not concerning to Arneson until July 30 when he and a co-worker were moving slot machines at the Mineral Palace and he suffered an episode of supraventricular tachycardia (SVT).[1]

Arneson immediately went to the Lead-Deadwood Emergency

[1] "Supraventricular tachycardia" is "any cardiac rhythm exceeding 100 beats per minute that originates above the ventricles, in the SA node, atria, or AV junction." *Mosby's Medical, Nursing, and Allied Health Dictionary* at 1510 (4th Ed. 1994).

Department. His heart rate was 195 beats a minute, blood pressure was only 76/48, and he was experiencing chest pain, dizziness, and heart palpitations. (DI 0398-1543.) The staff immediately admitted Arneson and started to treat him for his symptoms, which included stopping his heart for over four minutes to try to get it reset. (HT 32:18-33:4.) He was then transferred to the Intensive Care Unit where he was treated for the next two and a half days. (HT 33:5-12.) Claimant's doctor, James Holloway, treated Claimant on July 30 and diagnosed him as suffering from atrial fibrillation (AFib) and hyperthyroidism. Dr. Holloway explained in the medical records:

> The electric shock wave clearly passed through his heart, as the entry point was his right hand and the exit point was his left foot. Electric shocks like this can lead to electrical instability of the heart persist for some time beyond the shock itself, even if the shock itself was not immediately associated with the development of arrhythmias. Therefore, I believe we must consider his atrial fibrillation as work-related, having been either triggered or significantly exacerbated by the electrical shock.

(DI 0603.) Claimant had not had any episodes of heart palpitations, thyroid issues, or heart issues prior to being electrocuted on July 18. (HT 33:13-21.)

After he was discharged from the hospital Claimant continued to experience heart palpitations which would cause him to fatigue. (HT 33:22-34:7.) In the beginning, the AFib would happen approximately four times a day which would cause Claimant to have to rest for anywhere from a few minutes to a half an hour. (HT 34:8-35:5.) Over

the course of the next four years, Claimant's doctors prescribed medications and even killed his thyroid to try to control his AFib and episodes of SVT; however, nothing has been successful in eliminating these episodes. (HT 36:1-37:11.)

Despite getting electrocuted, and suffering from AFib and numbness in his right hand, Claimant continued to try to work at the Mineral Palace. (HT 37:12-15.) However, Arneson was unable to do his job without help from his fellow employees. (HT 37:18-38:6.) As Claimant explained, he could not lift and move machines or furniture, and even had a difficult time just walking across the casino. (HT 37:18-38:19.) On June 1, 2019, Arneson decided he had to quit working at the Mineral Palace because of his AFib, fatigue, and right-hand numbness rendered him unable to perform his job duties.[2] (HT 39:20-17.)

As of the date of the Hearing, Claimant was still having significant difficulties with the numbness in his right hand and symptoms from his AFib. The main problem with his hand is that he cannot gauge how hard or soft he is holding objects because of the loss of sensation and numbness. (HT 97:16-19.) He currently suffers from episodes of AFib three to four times per day, which requires him to rest for a few minutes, but if it is really bad, he has to lay down. (HT 94:14-95:3.) Arneson still does projects around the house, but what used to take him a day or two now takes him weeks to finish. (HT 99:11-25.) As of the date of the

[2] Claimant testified he is right-hand dominant. (HT 40:18-19.)

hearing, Claimant was still experiencing ongoing issues with numbness and sensation and the Department determined that the electrical shock was still a major contributing cause of his current condition. (App. 34.)

D. Testimony from Claimant's Co-Employees and Supervisors

Brian Ledbetter worked maintenance at the Mineral Palace with Arneson on a daily basis for approximately three and one-half years. (HT 104:12-24.) Arneson was Ledbetter's supervisor, and they would work together constantly throughout the day. (HT 105:5-10.) Ledbetter was also tasked to perform the same job duties that Claimant had to do while working in maintenance for the Mineral Palace. (HT 105:11-106:6.)

Ledbetter explained that prior to getting electrocuted Arneson was "extremely" strong and did not need any help performing his job functions. (HT 106:11-25.) After Arneson was electrocuted, he did not have the strength to do his job and would have to rest to get through things. (HT 106:16-107:12.) Lifting a 40-pound bag of salt was too much for Arneson after his injury and any exertion would result in him having to just sit in a chair to rest. (HT 107:13-22.) Ledbetter recounted how after his injury Arneson would basically have the other employees do all the work. (HT 108:14-23.)

Connie Teale is Arneson's significant other, and they have been living together since 2014. (HT 115:16-116:1.) Teale explained that prior to getting electrocuted Arneson did not have any problems medically and was able to handle all of his activities of daily living without any

problems. (HT 116:25-117:14.) She explained that Arneson experiences episodes of AFib day and night to the point it wakes him up every few hours leaving him tired and worn out. (HT 117:15-118:8.) Arneson still tries to help with household chores, but everything takes longer because of his AFib and he has difficulty grasping objects because of the numbness in his hand. (HT 118:9-119:12)

Kurt Hall was employed by the Mineral Palace as the floor supervisor during the time Arneson was working there. (HT 178:2-6.) Hall would typically see Arneson on a daily basis when they were both working. (HT 179:14-18.) Hall testified Arneson was a good employee that was always willing to help out others at the casino. (HT 180:1-9.)

Diana Prado was the assistant manager at the Mineral Palace during the time Arneson was the maintenance manager. (HT 192:13-16.) Prado would also interact with Arneson on a daily basis. (HT 194:10-195:5.) She described Arneson as a hard worker who was hands on and active and always willing to help out anybody else in any different area. (HT 195:6-14.) Arneson was "[d]ependable [and] arrived on time all the time." (HT 195:15-22.) Prado did Arneson's performance reviews—rating him at good to exceptional and agreed he was a fantastic employee. (HT 205:8-23; 206:25-207:3.)

The Insurer denied Arneson's worker's compensation claim on May 10, 2019, and Prado was supplied a copy of that letter. (HT 208:4-19.) After Prado received the denial letter, she did not reach

out to Arneson. (HT 208:20-25.) Prado also received a copy of the Petition for Hearing and, after reading it, she also did not reach out to Arneson to let him know there was still a job for Arneson at the Mineral Palace or that they were willing to accommodate his restrictions. (HT 209:2-15.) As of the date of the Hearing, the Mineral Palace had still not offered any job to Claimant. (HT 210:2-211:21.)

VI. ARGUMENT

A. Standard of Review

This Court has explained: "In an appeal from a circuit court's review of an administrative agency's decision, we review the agency's decision unaided by any presumption that the circuit court's decision was correct." *Tucek v. S. Dakota Dep't of Soc. Servs.*, 2007 S.D. 106, ¶ 12, 740 N.W.2d 867, 870 (internal quotations and citation omitted). This Court's review of a decision from the Department is controlled by SDCL § 1-26-36. "Whether the claimant made a prima facie case that he belongs in the odd lot total disability category is a question of fact." *Lends His Horse*, 2000 S.D. 146, ¶ 9, 619 N.W.2d 516, 519; *quoting Shepherd v. Moorman Mfg.*, 467 N.W.2d 916, 919 (S.D. 1991). "The test to determine whether a prima facie case has been established is whether there are facts in evidence which if unanswered would justify persons of ordinary reason and fairness in affirming the question which the plaintiff is bound to maintain." *Billman v. Clarke Mach., Inc.*, 2021 S.D. 18, ¶ 29, 956 N.W.2d 812, 820–21 (internal quotations and citations omitted).

"This Court will not overturn the Department's determination that a claimant met his prima facie burden showing that he belongs in the odd-lot total disability category, unless such a finding is clearly erroneous." *Stang v. Meade Sch. Dist. 46-1*, 526 N.W.2d 496, 498 (S.D. 1995) (citations omitted). "This court has held that a fact found by the court although expressed as a conclusion of law will be treated on appeal as a finding of fact." *Jerke Const., Inc. v. Home Fed. Sav. Bank*, 2005 S.D. 19, ¶ 22, 693 N.W.2d 59, 65 (quotations and citation omitted).

"The test is whether after reviewing the evidence we are left with a definite and firm conviction that a mistake has been made." *Hughes v. Dakota Mill & Grain, Inc.*, 2021 S.D. 31, ¶ 12, 959 N.W.2d 903, 907 (quoting *Schneider v. S.D. Dep't of Transp.*, 2001 S.D. 70, ¶ 10, 628 N.W.2d 725, 728). "The Department's factual findings and credibility determinations are reviewed under a clearly erroneous standard." *Sauder v. Parkview Care Center*, 2007 S.D. 103, ¶ 11, 740 N.W.2d 878, 883 (*Kuhle v. Lecy Chiropractic*, 2006 S.D. 16, ¶ 15, 711 N.W.2d 244, 247). Further, "when findings of fact are made based on live testimony, the clearly erroneous standard applies" and "[d]eference and great weight are given to the hearing examiner on fact questions." *Tucek*, 2007 S.D. 106, ¶ 13, 740 N.W.2d 867, 871 (citing *VanSteenwyk v. Baumgartner Trees & Landscaping*, 2007 S.D. 36, ¶ 10, 731 N.W.2d 214, 218).

In reviewing factual findings of an administrative decision, "[t]he question is not whether there is substantial evidence contrary to the

findings, but whether there is substantial evidence to support them." *Abild v. Gateway 2000, Inc.*, 1996 S.D. 50, ¶ 6, 547 N.W.2d 556, 558. This Court explained: "The issue we must determine is whether the record contains substantial evidence to support the agency's determination." *Helms v. Lynn's, Inc.*, 1996 S.D. 8, ¶ 10, 542 N.W.2d 764, 766 (citation omitted). However, "when 'an agency makes factual determinations on the basis of documentary evidence, such as depositions or medical records' the review is de novo." *McQuay v. Fischer Furniture*, 2011 S.D. 91, ¶ 10, 808 N.W.2d 107, 111 (citing *Darling v. W. River Masonry, Inc.*, 2010 S.D. 4, ¶ 10, 777 N.W.2d 363, 366-67).

ISSUE 1: The Circuit Court Erred In Reversing The ALJ's Determination That Claimant Proved His Workplace Injury Was A Major Contributing Cause Of His Developing Atrial Fibrillation.

The Circuit Court issued a Memorandum Decision explaining why it was "persuaded" Arneson failed to establish that the electrocution event was a major contributing cause of his developing AFib, thereby reversing the Department. The summation of the Circuit Court's rationale for reversal was that: "This Court is persuaded by the findings of Dr. Brody and Dr. Elkins in light of the totality of the circumstances surrounding Arneson's injury, symptoms, and response to medication." (App. 8.) However, the fact that the Circuit Court was "persuaded" by the evidence presented by the Appellants is not the relevant inquiry.

The Circuit Court's reversal is erroneous because the Circuit Court failed to follow the clear standards of review for appellate courts. In fact, at no point in its decision did the Circuit Court state it was giving great weight or deference to any of the Department's factual determinations. The Circuit Court also did not explain why or how the Department's findings or determinations were "clearly erroneous" thereby justifying reversal. Nor did the Circuit Court explain why it was "left with a definite and firm conviction that a mistake has been made." All that the Circuit Court did was explain why it was substituting its judgment for that of the Department. *See McKibben v. Horton Vehicle Components, Inc.*, 2009 S.D. 47, ¶ 18, 767 N.W.2d 890, 897 ("The circuit court's judgment cannot be substituted for the judgment of the Department regarding the weight of the testimony and evidence.")

A. Claimant met his burden of proof that his injuries arose out of his employment and were a major contributing cause of the impairment and disability.

"A claimant who wishes to recover under South Dakota's Workers' Compensation Laws must prove by a preponderance of the evidence that he sustained an injury arising out of and in the course of the employment." *Fair v. Nash Finch Co.*, 2007 S.D. 16, ¶ 9, 728 N.W.2d 623, 628 (quotations and citations omitted). A claimant does not need "to prove that the work injury was 'the' major contributing cause, only that it was 'a' major contributing cause, pursuant to SDCL 62-1-1(7)." *Orth v. Stoebner & Permann Const., Inc.*, 2006 S.D. 99, ¶ 42, 724 N.W.2d 586,

596 (citation omitted). This Court went on to explain that "[t]here are no 'magic words' needed to express an expert's degree of medical certainty, and the test is only whether the expert's words demonstrate that he or she was expressing an expert medical opinion." *Id.*, 2006 S.D. 99, ¶ 44, 724 N.W.2d at 596.

This Court has explained that "[u]nder South Dakota law, insofar as a workers' compensation claimant's pre-existing condition is concerned, we must take the employee as we find him." *Id.*, 2006 S.D. 99, ¶ 48, 724 N.W.2d at 597 (internal quotations and citation omitted). "If a compensable event contributed to the final disability, recovery may not be denied because of the pre-existing condition, even though such condition was the immediate cause of the disability." *Id.* (internal quotations and citation omitted). "[A] pre-existing medical condition or infirmity does not disqualify a claim under the 'arising out of employment' requirement if the employment aggravated, accelerated, or combined with the condition or infirmity to produce the disability for which compensation is sought." *St. Luke's Midland Regional v. Kennedy*, 2002 S.D. 137, ¶ 13, 653 N.W.2d 880, 884–85.

B. The Circuit Court did not give great weight or deference to the Department's factual determinations or explain why those determinations were clearly erroneous.

The Circuit Court acknowledged that it was required to give great weight and deference to the Department's factual determinations. (App. 5.) At no point in its decision, however, did the Circuit Court

actually apply that legal precept to any of the Department's findings. In fact, the Circuit Court actually ignored and omitted from its decision multiple factual determinations the Department found significant in finding for Claimant.

The Circuit Court initially followed and incorporated the Department's findings and conclusions when it set forth its recitation of the facts and in its analysis. (App. 2-4.) However, the Circuit Court then excluded several relevant findings from its recitation. One of the significant findings the Circuit Court failed to identify or discuss was that Drs. Brody and Elkins admitted they were not experts when it came to testifying about Arneson's medical conditions. Similarly, it neglected to address the fact Dr. Brody only performed a records review and Dr. Elkins' testimony was live at hearing, making the Department's decision to not adopt Dr. Elkins opinions more significant and subject to a heightened level of deference. *See Tucek*, 2007 S.D. 106, ¶ 13, 740 N.W.2d at 871 ("when findings of fact are made based on live testimony, the clearly erroneous standard applies" and "[d]eference and great weight are given to the hearing examiner on fact questions.") (citations omitted). Finally, it also ignored the fact the Department found Claimant's testimony to be credible. This failure to even attempt to follow the appropriate standard of review, and the omission of these relevant factual findings or any analysis, renders the Circuit Court's decision erroneous as a matter of law.

C. The Department found the testimony of Dr. Holloway more persuasive than the testimony of Drs. Brody and Elkins and that finding was not clearly erroneous and is supported by substantial evidence.

The Department read the depositions of Drs. Holloway and Brody and listened to the live testimony of Dr. Elkins. It then listed in its Decision the nature of each expert's role in the case (Dr. Holloway, treating provider; Dr. Brody, records review; and Dr. Elkins, IME) along with that expert's qualifications and experience. Based on its role as factfinder the Department went on to explain why it was persuaded more by the testimony of Dr. Holloway than the other medical witnesses:

> 124. Dr. Holloway testified that the most common injuries following an electrical injury are to the heart and such injuries can cause long term effects.
>
> 125. Additionally, he considered the fact Arneson developed heart palpitations within a short time period significant.
>
> 126. The Department is persuaded by Dr. Holloway's analysis and his conclusion that it is more likely than not that Arneson developed AFib as a result of the electric shock.

(App. 57.) The Circuit Court did not present any explanation as to why the Department was clearly erroneous in finding that Dr. Holloway was more persuasive than the other medical witnesses when Dr. Holloway's opinions were based off of probabilities and backed up by the medical records and medical history.

Significantly, in reaching its decision, the Department also discussed Dr. Brody's and Dr. Elkins' lack of expertise:

> 56. At deposition, Dr. Brody answered no to questions regarding whether he considered himself an expert in treating and testifying about thyroid problems or individuals that had hyperthyroidism that had been subject to electrical shock.
>
> . . . .
>
> 96. At hearing, Dr. Elkins was asked a series of questions about his expertise.
>
> 96. [sic] He answered that he did not consider himself an expert in treating patients with AFib, Graves' Disease, thyroid problems, or cardiac problems.
>
> 97. He was also asked if he had special training in these areas or whether he treated thyroid problems on a continuing basis. His answer indicated that he did not.

(App. 50, 54.) The Circuit Court presented no discussion as to why these findings were clearly erroneous.

Even if the Circuit Court did argue these findings were clearly erroneous, such an argument would be unsupported by the record. Dr. Holloway testified that being electrocuted was more likely the cause of Arneson developing atrial fibrillation because "only about 5 to 15 percent of patients with hyperthyroidism will develop atrial fibrillation." (DI 1837; *see generally Orth*, 2006 S.D. 99, ¶ 44, 724 N.W.2d at 596 ("There are no 'magic words' needed to express an expert's degree of medical certainty, and the test is only whether the expert's words demonstrate that he or she was expressing an expert medical opinion.").) Employer and Insurer's medical witnesses, on the other hand, testified that it is more likely that Claimant spontaneously developed atrial fibrillation 12 days after he was electrocuted as a result of his previously

asymptomatic Graves' Disease and hyperthyroidism suddenly becoming symptomatic. If anything, Employer and Insurer's witnesses are merely speculating as they cannot point to any reason as to why Arneson's Graves' Disease and hyperthyroidism would suddenly become symptomatic and cause him to develop SVT and atrial fibrillation.

Moreover, the Department's discussion that Drs. Elkins and Brody are not experts with regard to Arneson's medical conditions is supported by the record. Dr. Elkins admitted that he does not have any expertise regarding Claimant's medical conditions and injuries. As such, the Department was correct, and did not commit clear error, in rejecting Dr. Elkins' opinions.

Dr. Elkins is a preventative and occupational medicine doctor. Preventative medicine doctors "apply their knowledge and skills in medicine, social, economic, and behavioral sciences to improve the health and quality of life of individuals, families, communities and populations through disease prevention and health promotion." (HT 251:8-17.) "Occupational medicine focuses on the physical and mental health of workers by seeking to improve the physical, structural and social conditions of the workplace." (HT 251:8-17.) Dr. Elkins no longer treats patients, but does do approximately 25 IMEs and records reviews a month and 99% of the time it is at the request of insurance companies or their attorneys. (HT 257:8-258:7.)

Dr. Elkins agreed that Arneson's case involves the interplay between multiple medical conditions including: cardiology, A-fibrillation, thyroid and Graves' Disease. (HT 252:17-22.) Dr. Elkins also agreed that he was not an expert, and had no special training, when it came to electricity, cardiology, atrial fibrillation, thyroid problems, or Graves' Disease:

Q Do you have any special training as an electrician?

A No.

Q Are you an electrical engineer?

A No.

Q Would you agree with me you're not an expert on electricity?

A I would agree.

. . . .

Q You have no special training in cardiology?

A No.

Q You're not qualified to treat patients with cardiac problems like atrial fibrillation?

A I don't do it as part of my practice. I think this came up last time, too.

Q Okay.

A I mean, I was -- I did an internship in family practice. I most certainly did treat people with atrial fibrillation as part of my training. The specialty I went into doesn't treat that.

Q You have never treated people with cardiac problems on a continued and sustained basis?

A The same for atrial fibrillation. Treating them, being their family doctor isn't what occupational medicine is, but I did do that in my training in family practice.

Q I understand that. But your answer was no before, that you did not treat people with cardiac problems on a continued and sustained basis. Was that an accurate answer?

A I do not treat that, right. Not as part of my practice.

Q Okay. And aside from your family practice internship, you have no special training or education or schooling in cardiology?

A Correct.

Q And you don't consider yourself an expert in treating patients with cardiac problems?

A Correct.

Q You don't consider yourself an expert in treating patients with atrial fibrillation?

A Correct.

Q You have not treated patients with thyroid problems on a continuing basis?

A Correct.

Q You don't consider yourself an expert in treating patients with thyroid problems?

A Correct.

Q You don't actively treat patients that have Graves' Disease?

A Correct.

Q You don't consider yourself to be an expert in treating patients with Graves' Disease?

A Correct.

(HT 254:3-256:9.) Based on his own testimony, the Department was correct in not adopting the opinions of Dr. Elkins, as he is not qualified to testify whether Claimant's injuries and conditions were, or were not, caused when Claimant was electrocuted.

Dr. Brody, like Dr. Elkins, also does not have any special training or expertise when it comes to treating patients with hyperthyroidism. In his 31 years as a cardiologist, he has never treated anybody for thyroid problems. (Richard Brody, M.D., Dep. at 23:15-23, Jan. 6, 2021.) Dr. Brody also admitted he does not consider himself an expert in treating and testifying about hyperthyroidism. (*Id.* at 24:4-16.) Moreover, Dr. Brody never examined Arneson, but instead just conducted a records review. (*Id.* at 25:8-10.) This is significant because this Court has held: "The opinion of an examining physician should be given substantial weight when compared to the opinion of a doctor who only conducts a review of medical records." *Peterson v. Evangelical Lutheran Good Samaritan Society*, 2012 S.D. 52, ¶ 23, 816 N.W.2d 843, 850 (citation omitted). The Circuit Court's decision did not even address this legal tenet, let alone discuss how, or why, it agreed with Dr. Brody's opinions while at the same time giving substantial weight to Dr. Holloway's opinions. As such, the Department's decision to accept Dr. Holloway's opinions over Dr. Brody's opinions, when viewed through this standard, is not clearly erroneous.

D. The Department found Claimant to be credible and that finding was not clearly erroneous and is supported by substantial evidence.

This Court has consistently explained that "[t]he Department's factual findings and credibility determinations are reviewed under the clearly erroneous standard [and] we will reverse those findings only if we are definitely and firmly convinced a mistake has been made." *Wise v. Brooks Const. Servs.*, 2006 S.D. 80, ¶ 16, 721 N.W.2d 461, 466 (citations omitted). "Due regard shall be given to the opportunity of the agency to judge the credibility of the witness." *Bonnett v. Custer Lumber Corp.*, 528 N.W.2d 393, 396 (S.D. 1995) (citation omitted). A reviewing court does "not substitute [its] judgment for the Department's on the weight of the evidence or the credibility of the witness." *Mettler v. Sibco, Inc.*, 2001 S.D. 64, ¶ 7, 628 N.W.2d 722, 724 (citations omitted). Finally, in *Schneider*, this Court stated:

> Where there are two permissible views of the evidence, the factfinder's choice between them cannot be clearly erroneous. Determining the credibility of the witnesses is the role of the factfinder. Where the Department has resolved conflicts in evidence, we cannot change its findings.

2001 S.D. 70, ¶ 14, 628 N.W.2d at 729-30.

At the hearing, Claimant explained how the palpitations began and evolved:

> Q Okay. In the days that started to follow July 18th, what did you start to experience with your heart?
>
> A The minor palpitations actually for the first couple days I -- okay. It's just a fluke, you know. But I did

call on the 20th and I said, okay, because of my worksheet, it said, If you experience any of these, I went over it, and I said -- you know, I explained to Joe that I'm starting to have heart palpitations or they call it AFib.

Q And over the next following, you know, ten, eleven days, did you continue to have these heart palpitations?

A I had continued palpitations and they -- the small ones seemed to get worse, but the big ones, now that I know, the big ones didn't start coming yet.

(HT 29:19-30:8.) The Department found this testimony credible as stated under the Analysis section of its decision, in Conclusion of Law 121: "The Department finds Arneson's testimony to be credible and believes that he did experience palpitations that he disregarded until they became serious enough that he went to the emergency department on July 30, 2018." (App. 57.)

On appeal, a reviewing court does not consider factual determinations in isolation, but "in light of the entire evidence." *Stang*, 526 N.W.2d at 498 (S.D. 1995) ("An agency's factual determinations will be overruled only if this Court finds them to be 'clearly erroneous' in light of the entire evidence.") (citation omitted). This legal principle is significant in this case because the Department had the opportunity to listen to multiple live witnesses testify on the underlying issues, including: Arneson, Brian Ledbetter (co-worker), Connie Teale (Claimant's girlfriend), Tom Audet (Claimant's vocational consultant), Kurt Hall (Mineral Palace gaming manager), Diana Prado

(Mineral Palace assistant general manager), Dr. Elkins (Employer and Insurer's medical witness), and James Carroll (Employer and Insurer's vocational consultant). Based on this live testimony and the documentary evidence, the Department found Claimant credible, that he did experience heart palpitations shortly after being electrocuted, and issued a fully favorable decision. Again, the Circuit Court provided no analysis as to why these findings were "clearly erroneous" or how it was "definitely and firmly convinced a mistake has been made."

Regardless, the record reveals that the Department's decision on this issue is supported by substantial evidence. Arneson testified he ignored, and did not go back to the doctor for those palpitations, until 12 days later when he was at work and experienced an extremely rapid heart rate, started sweating, and became dizzy. (HT 31:16-32:17.) Notably, Dr. Elkins agreed with Dr. Holloway that it is "very common for people who have developed sustained atrial fibrillation to initially have some brief transient palpitations that they don't think much of and ignore but then they come in with a full-blown atrial fibrillation episode." (HT 273:20-274:7.) Moreover, Dr. Brody testified that if Arneson had heart palpitations days after the event "I guess he had it." (Brody Dep. 25:17-23.) When asked whether he puts more credence in someone's recollection years later, or the medical records taken at the time of the event, Dr. Brody said "the most important test is really when you ask a patient a question and they tell you the answer[.]" (*Id.* at 42:22-43:8.)

Lastly, Kurt Hall, Arneson's floor supervisor at the Mineral Palace, testified at hearing regarding Arneson's work ethic prior to being electrocuted. Hall testified that prior to July 18 Arneson did not have any problem doing his job, he was not a complainer, and was there to work. (HT 189:25-190:9.) Hall also testified that he does not dispute that Arneson talked to him about how he was having heart issues in the days after he was electrocuted:

> Q And, you know, you talked about how he did talk to you after the incident how he had some heart issues, is that right?
>
> A Yes.
>
> Q All right. If Mike testified he talked to you about those heart issues a few days after he was electrocuted, would you have any reason to dispute that?
>
> A No.

(HT 190:10-18.) The evidence and testimony cited above constitutes substantial evidence supporting the Department's determination that Arneson was having transient palpitations in the days after he was electrocuted and just hoped they would go away before his SVT event on July 30.

1. Drs. Elkins and Brody agreed that medical articles confirmed that low-voltage electrical shock was found to have caused atrial fibrillations weeks after the event.

The Department made several other conclusions based on the doctors' testimony and documentary evidence regarding the probability of developing AFib from electrical shock:

109. The data provided by the doctors shows that developing AFib whether due to electrical shock or hyperthyroidism is uncommon.

110. Arneson developed an uncommon condition and the question before the department is whether it is probable that the electrical shock he experienced on July 18, 2018, was a major contributing cause of that condition.

111. Having reviewed the record and the doctors' opinions, the Department finds that it is probable that the electric shock experienced by Arneson is a major contributing cause of his development of AFib and his current condition.

112. Dr. Brody and Dr. Elkins opined that it was very rare for AFib to be caused by an electrical shock and had the injury caused the AFib, the symptoms would have appeared soon after the shock.

113. However, both doctors testified that there have been cases of AFib after an electrical shock and cases where an individual's shock related AFib developed later.

(App. 56.)

In its summation on this issue, the Circuit Court placed great weight on Dr. Brody's testimony that he "found just one case study in the last 70 years where there was a delayed development of AFib following an electrical shock." (App. 8.) The Circuit Court also relied on the fact that Dr. Elkins' review of the studies indicated "that there was a less than 1 in 1,000 percent chance that Arneson developed AFib as a result of electrical shock." (*Id.*) It concluded by stating: "Arneson offered no evidence to counter the testimony of Dr. Brody and Dr. Elkins." (*Id.*) These statements are not accurate.

On cross examination, Dr. Elkins agreed Claimant was subjected to four times as much as the typical electricity delivered to a home and

the electricity went into his right hand and out his left foot causing burns on, and numbness in, his fingers. (HT 259:2-13.) Dr. Elkins agreed that shortly after the event Claimant was experiencing paresthesia in his right thumb and fingertips. (HT 264:15-265:9.) Dr. Elkins also agreed that on July 30, Arneson was also experiencing a very fast heartbeat and chest pain, which are all symptoms and signs of somebody who suffered electrical shock injury pursuant to Exhibit 4 - Electrical Shock Injury Form. (HT 267:2-268:24; App. 68.)

In his records review, Dr. Elkins stated that he "was not able to locate any studies showing a synergistic effect (the hypothesized delayed effect of the electrocution and the hyperthyroidism combining to produce the atrial fibrillation) . . . ." (DI 1582.) However, on cross examination, Dr. Elkins admitted that it is possible for a person that is electrocuted to develop arrhythmias days after the event. (HT 269:16-23.) In fact, Dr. Elkins conceded that Exhibit 10, a medical article which he cited in his report, showed that low voltage electrocution can cause cardiac injuries including myocardial necrosis with ventricle fibrillation and arrhythmias. (HT 270:7-271:19, DI 1596-1602.) Dr. Elkins also agreed that Exhibit 11, which was also a medical article cited in his report, similarly explained that electrical shock may cause direct myocardial necrosis or cardiac arrhythmia. (HT 271:20-272:23, DI 1603-12.)

Ultimately, Dr. Elkins testified he could not link together the electrocution event and Arneson's hand numbness and atrial fibrillation.

However, Dr. Elkins did concede that prior to being electrocuted Arneson's hyperthyroidism and Graves' Disease were asymptomatic and not giving him any problems. (HT 276:2-11.) Dr. Elkins also agreed there were no reports of symptoms that would have caused Arneson to be diagnosed with atrial fibrillation prior to being electrocuted on July 18, 2018. (HT 276:12-15.) The Department was able to observe Dr. Elkins while being impeached on these issues which, again, is why reviewing courts give so much deference to the fact finder.

The Circuit Court placed great weight on Dr. Elkins' testimony "that there was a less than 1 in 1,000 percent chance that Arneson developed AFib as a result of the electric shock." (App. 8.) Other than Dr. Elkins' bare assertion to that statistic, however, there is absolutely no support in any of the cited medical articles for the accuracy of that statistic. In fact, Dr. Elkins did not even state this statistical improbability in either his records review or IME report. (*See* DI 1578, 1585 (Exs. 8 and 9).) It would appear this number was simply pulled out of thin air by Dr. Elkins during his hearing testimony. Again, based on Dr. Elkins' admitted lack of expertise or special training on electricity, cardiology, atrial fibrillation, thyroid problems, and Graves' Disease, as well as the Department's ability to view his testimony live, this statistic cannot constitute evidence that would give an appeal court a definite and firm conviction a mistake has been made.

2. Dr. Brody agreed that medical articles confirmed low-voltage electrical shock was found to have caused atrial fibrillations weeks after the event.

In considering the evidence presented by Employer and Insurer, it is important to recognize that Dr. Brody also agreed that when Arneson presented to the emergency department on July 30 that he was experiencing tingling and numbness in his fingers, very bad pain, skin burns, and a fast and irregular heart beat—as set forth on Exhibit 4. (*Id.* at 28:3-29:3; DI 1555-60.) Dr. Brody conceded it was possible that the electricity went through Arneson's heart even though there was no structural heart disease on examination. (*Id.* at 29:13-30:13.)

In addition, delayed onset of atrial fibrillation is not unheard of after a person is electrocuted or even suffers a low-voltage shock. Dr. Brody discussed that he found an article where a patient suffered a low-voltage shock and then developed atrial fibrillation six weeks after the event. (*Id.* at 30:14-31:2.) Dr. Brody agreed with the conclusions of the article:

> Q And the conclusion of this article is that low-voltage electrocution may cause cardiac insult. You'd agree with that?
>
> A Yup.
>
> Q It can cause myocardial necrosis with ventricle fibrillation and also arrhythmias?
>
> A Yes.
>
> Q And in this case the subject was wholly subjected to low voltage of 220 to 240 volts and she did develop atrial fibrillation; is that right?

A It was diagnosed six weeks after it occurred. There was six weeks between the diagnosis and the injury -- the atrial. The electrical injury was six weeks before the atrial fib.

(*Id.* at 32:8-21.) Dr. Brody also agreed that "the heart is one of the most susceptible organs to electrical injury [and] electrical shock may cause direct myocardial necrosis or cardiac arrhythmias to the heart." (*Id.* at 34:6-16.) This circumstance is similarly evidenced by the other medical articles marked as Exhibits 10, 11, and 12. (DI 1596-1619.)

Dr. Brody agreed with Dr. Holloway that it is very common for people after an electrical injury to have rhythm disturbances and that anything is possible when it comes to atrial fibrillation:

Q During his deposition Dr. Holloway stated, "It is very common for people after an electrical injury to have rhythm disturbances" is that accurate?

A That's accurate.

Q Why is that?

A Because they can -- it's just something that's observed. You know, people can get heart damage, the stress of the injury, it can trigger skipped heartbeats. You know, if somebody gets some damage to the heart muscle, that can trigger dangerous abnormal heart rhythms. And as we pointed out, atrial fib has been reported after an electrical injury.

Q One of the things Dr. Holloway explained was that these rhythm disturbances can sometimes last for a few seconds to a few minutes and that it was very common for people with atrial fibrillation, as Mr. Arneson did, to initially have some brief transient palpitations that they don't think much of and ignore, but then they come in with a full-blown atrial

fibrillation episode. Do you agree with that statement, and if so, can you explain?

A I agree with it. Anything is possible. It's possible that a person could have short bursts of atrial fib and then have sustained atrial fib. It's possible that a person could have some palpitations due to some skipped heartbeats that aren't atrial fib and then they come in with atrial fib. Atrial fib, at least from a cardiologist's standpoint, it's so common that anything can happen.

(Brody Dep. 36:1-37:5.)

There are multiple other admissions by Dr. Brody which constitute substantial evidence supporting the Department's decision that the electrocution event on July 18 was a major contributing cause of Arneson's subsequent condition and need for medical treatment:

- Dr. Brody testified that it was unlikely that Arneson had atrial fibrillation prior to being electrocuted. (*Id.* at 38:14-39:2.)
- Dr. Brody testified Arneson most likely had hyperthyroidism prior to July 18 and it was not causing him any symptoms before that and was not causing any atrial fibrillation prior to the July 18 electrical shock. (*Id.* at 39:7-23.)
- Dr. Brody was not aware of any event between July 18th and July 30th, other than the electrical shock, that would cause Arneson to go into atrial fibrillation. (*Id.* at 40:7-12.)
- Dr. Brody was not aware of any event between July 18th and July 30th, other than the electrical shock, that would cause Arneson's hyperthyroidism to become symptomatic and cause atrial fibrillation. (*Id.* at 40:18-22.)
- Dr. Brody did not know what would cause Arneson's hyperthyroidism to become symptomatic and cause him to go into atrial fibrillation on July 30. (*Id.* at 40:23-41:3.)

These admissions, when compared with the testimony of Dr. Holloway, show that it was more likely than not that Claimant being electrocuted on July 18 was a major contributing cause of his injuries, condition, and need for treatment. The testimony cited above constitutes substantial evidence supporting the Department's determination that Dr. Holloway's opinions were more persuasive when both Drs. Elkins and Brody "testified that there have been cases of AFib after an electrical shock and cases where an individual's shock related AFib developed later." (App. 26.)

ISSUE 2: The Circuit Court Erred In Reversing The ALJ's Determination That Claimant Proved He Was Permanently And Totally Disabled And Was Entitled To Benefits Under The Odd-Lot Category.

The Department held Claimant made a prima facie showing he was obviously unemployable and entitled to benefits under the odd-lot category. (App. 29-35.) On appeal, Employer and Insurer argued that Arneson was employable because he continued to work for Employer until he retired on June 1, 2019. (DI 1848-53.) The Circuit Court reversed the Department's determination that Arneson proved he was "obviously unemployable or permanently and totally disable[d]" because Arneson voluntarily left the job market and failed to return to his position with the Mineral Palace. (App. 9-10.)

Similar to the arguments set forth in issue one above, the Circuit Court again failed to set forth any analysis showing that it conducted the appeal pursuant to the appropriate standards of review. It did not

explain why the Department's factual determinations were "clearly erroneous" or why it was "left with a definite and firm conviction that a mistake has been made." Again, the Circuit Court just substituted its opinion for that of the Department. The Circuit Court's failure to follow the appropriate standards of review renders its decision erroneous as a matter of law.

A. Employer and Insurer failed to meet their burden of proof showing that some form of suitable work is regularly and continuously available to Arneson in the community.

Once a claimant makes a prima facie showing of permanent total disability "[t]he burden then shifts to the employer to show that some form of suitable work is regularly and continuously available to the employee in the community. The employer may meet this burden by showing that a position is available which is not sporadic employment resulting in an insubstantial income as defined in subdivision 62-4-52(2)." SDCL 62-4-53. "A claimant who has shown that he is obviously unemployable does not bear the additional burden of demonstrating that he made reasonable efforts to find employment in the competitive market before the burden shifts to the employer." *Billman*, 2021 S.D. 18, ¶ 42, 956 N.W.2d at 823 (internal quotations and citation omitted).

B. The Circuit Court did not give great weight or deference to the Department's factual determinations or explain why those determinations were clearly erroneous.

The Circuit Court initially followed and incorporated the Department's findings and conclusions when it set forth its analysis on

this issue. (App. 9-10; *see generally* App. 61-62 (citing COL 162-67).) However, the Circuit Court then excluded numerous relevant findings from its recitation that the Department set forth in reaching its determination that Arneson made the requisite showing he was entitled to permanent total disability benefits. Specifically, the Circuit Court did not address any of the findings and conclusions that discussed Arneson's physical restrictions or the testimony of the parties' vocational consultants. (*See* App. 62-65; citing COL 174-202).) There was no explanation why these pertinent factual determinations or conclusions were omitted from the Circuit Court's analysis or why they were clearly erroneous.

C. The Department's determination Claimant made a prima facie case he is obviously unemployable is not clearly erroneous and is supported by substantial evidence.

It is important to understand that under the first prong of the permanent total disability analysis, the Department found that Arneson was "obviously unemployable" based on his physical condition, age, training, and experience. (App. 30-34; *see* App. 64, COL 197: "The Department concludes that Arneson is obviously unemployable.") The Circuit Court did not present any evidence, or even discussion, that this finding was "clearly erroneous." Regardless, the Department's finding that Arneson was "obviously unemployable" is supported by substantial evidence.

Arneson introduced evidence at hearing that he was 67 years old, only had a GED education, and his work primarily consisted of heavy-duty jobs. (*See* HT 9:2-5, 10:7-12, 11:16-14:8.) Drs. Holloway and Elkins agree Arneson's restrictions set forth in Exhibit 6 were reasonable and there is no evidence disputing that Arneson will go into AFib three to four times per week which requires him to rest anywhere from 10 to 30 minutes at a time. (*See* App. 74; Holloway Dep. 22:7-24:9; HT 274:23-275:4.) In addition, vocational counselor Audet stated in his report, and testified at hearing, that it would be futile for Arneson to even do a job search given his age, restrictions, and worker's compensation rate. (HT 143:8-21.)

The Department, after reviewing all of the evidence and the record, agreed with Claimant's testimony, and Mr. Audet's judgment, that Claimant did make a prima facie showing that he is obviously unemployable. The Department also used caselaw to support its decision, stating:

> The Department concludes that Arneson is obviously unemployable. The Court has guided the Department to consider a claimant's situation in the aggregate. *Billman* at ¶ 41. Arneson has physical limitations that restrict what sorts of jobs he can do involving his hands, and he must take regular, unpredictable breaks of between 10 and 30 minutes. In *Billman*, the Court held, "outside of physically accommodating Billman, an employer would likely have to spend time and resources to train him-a person set to retire in a few years." *Id* at ¶ 39. The same can be said for Arneson who is within the age of retirement and would require training in a new position. Based on these facts, the

> Department finds that Audet's conclusion that Arneson is permanently and totally disabled is accurate.

(App. 33.) These findings and conclusions constitute substantial evidence in the record which supports the Department's determination.

Dr. Holloway explained Arneson could only work within the restrictions set forth in Exhibit 6. (Holloway Dep. 53:20-54:19; App. 74.) Claimant's physical restrictions listed in sections 1-5 of Exhibit 6 were completed by Audet based on his conversations with Arneson as to how much Arneson felt he could do based on his current medical condition. (HT 129:24-132:9.) The restrictions in sections 6-10 of Exhibit 6 are what Dr. Holloway was endorsing based on his treatment of Arneson. (HT 22:7-25:6; 52:5-6; 53:20-25.) The Circuit Court did not identify any evidence or testimony that the duration of, or amount of, those limitations are clearly erroneous or contrary to some other evidence. In fact, Employer and Insurer's own expert, Dr. Elkins, agreed with the restrictions set forth in Exhibit 6-Physical Capacities Form. (HT 274:8-275:4.)

The Circuit Court relied on this Court's opinion in *McClaflin v. John Morrell & Co.*, 2001 S.D. 86, 631 N.W.2d 180, to support its determination that Arneson was precluded from getting permanent total disability benefits because he voluntarily left the job market and failed to return to work at the Mineral Palace. (App. 9-10.) That was not the holding of *McClaflin* and the facts of that case are distinguishable from the facts in this case for several significant reasons.

In *McClaflin*, the claimant petitioned the Department of Labor for permanent total disability benefits despite the fact he was *currently* working for his employer, and four doctors, including his treating doctors, testified he was capable of working. 2001 S.D. 86, ¶ 4, 631 N.W.2d at 182. On appeal, the circuit court affirmed the award of odd-lot benefits, albeit for a different reason, that being it determined McClaflin "was obviously unemployable because he was not employable in the competitive market." *Id.* at ¶ 5, 631 N.W.2d at 182. The Supreme Court reversed the circuit court's finding because it had "never allowed recovery based on this test [competitive market test] . . . and decline[d] to adopt such an extension." *Id.* at ¶ 11, 631 N.W.2d at 184.

First, McClaflin had two jobs he was working when he had his hearing with the Department of Labor. Arneson, on the other hand, had stopped working at the Mineral Palace on June 1, 2019, and was not employed anywhere at the time of his hearing over three years later on September 24, 2022. Second, the circuit court in *McClaflin* reversed the Department's finding McClaflin was "obviously unemployable based on his physical condition, coupled with his education, training and age" and instead found claimant was obviously unemployable under the competitive market test. *Id.* at ¶ 11, 631 N.W.2d at 184. The Department in Arneson never stated Arneson was disabled because of the "competitive market test." As such, *McClaflin* is not helpful in this appeal. This leaves the Circuit Court's opinion bereft of any authority

that supports its decision that Arneson was not "obviously unemployable or permanently totally disable[d]" because he voluntarily left the job market and failed to return to work at the Mineral Palace.

D. Employer and Insurer did not meet their burden of showing there was some suitable employment within Claimant's limitations that was actually available in his community.

Although not clear, it would appear the Circuit Court's determination that Arneson is not "obviously unemployable" has nothing to do with the Department's findings regarding his physical condition, coupled with his age, training, and experience. Rather, it appears the Circuit Court is basing its decision that Arneson is not "obviously unemployable" or "permanently and totally disabled" on the fact he voluntarily left the job market (his job at the Mineral Palace) and "[h]is failure to return to his position cannot sustain an award." (App. 10.) The fact Arneson quit working at the Mineral Palace should not have been considered under the first inquiry, which is whether Arneson proved he was "obviously unemployable," but under the next step of the analysis set forth under SDCL 62-4-53: "[I]f the claimant is obviously unemployable, then the burden of production shifts to the employer to show that some suitable employment within claimant's limitations is actually available in the community." *Eite v. Rapid City Area School Dist. 51-4*, 2007 S.D. 95, ¶ 21, 739 N.W.2d 264, 270. This error is critical, because under the second step of the inquiry, Employer and Insurer have the burden of proof. Presumably, in considering the evidence

presented under the second step of the analysis, the only "suitable employment" the Circuit Court considered was Arneson's job at the Mineral Palace because the Circuit Court did not even identify the parties' vocational experts, let alone discuss their opinions and testimony.

Employer and Insurer did argue that "Claimant retired from work with Employer while he was not on work restrictions without asking for or discussing accommodations despite being able to perform his job full-time for 10 months." (DI 1857.) However, Arneson's injuries and limitations were not musculoskeletal in nature, which is what we typically see and deal with in these worker's compensation cases. Restrictions are most commonly seen as lifting restrictions for someone who injured a low back, neck, or shoulder. Restrictions are routinely given by doctors immediately in order to prevent the injured worker from lifting or doing too much and worsening or aggravating the injured body part. That scenario does not apply to Arneson's situation because he can do most things, but he becomes fatigued easily and his heart will start racing, requiring him to rest until it is under control. In these situations, the only person that really knows his or her limitations is the injured worker—in this case Arneson. So, it is not surprising that Dr. Holloway did not have any formal restrictions on Arneson as he was still recovering and it was up to him to know his limits.

Employer and Insurer also stated Arneson was working full-time up until he retired. While that is technically true, it ignores the fact that he was not doing hardly any of the job duties he had done for years prior to his electrocution on July 18, 2018. As Arneson explained, he could not walk across the casino without becoming fatigued and having to sit down and rest. (HT 38:7-19.) His co-worker Brian Ledbetter explained that any physical exertion would cause Arneson to have to sit and rest. (HT 107:13-22.) In June 2019, Arneson recognized he was not going to get better in order to be able to return to perform his job duties, so he quit. (HT 37:12-38:6.)

Employer and Insurer try to use this against Arneson and say his job was available to him and they would accommodate him. However, in answer to interrogatories asking if there were any jobs available at the Mineral Palace none were listed or offered to Arneson. (DI 1732-33; citing Ex. 37 at p. 4-5.) Diana Prado confirmed this at the hearing:

> Q Okay. But in this discovery request to know if there are any jobs available for my client and none were provided to him?
>
> A No. It sounds like none were provided.

(HT 210:14-17.) Moreover, as of the date of the hearing, nobody from the Mineral Palace had contacted Arneson and offered him his old job back, or any job for that matter, with or without restrictions. (HT 190:24-191:11 (Hall); 210:18-211:11 (Prado).)

The Circuit Court did not even discuss the fact that Employer and Insurer had the burden of proving that some form of suitable work is regularly and continuously available to Arneson in the community. It did not even reference the testimony of the parties' vocational consultants let alone analyze it under this part of the test in SDCL 62-4-53. Claimant submits that there is substantial evidence supporting the Department's determination that he made a prima facie case establishing odd-lot disability and that Employer and Insurer did not satisfy their burden of showing that there was some suitable employment within claimant's limitations that was actually available in his community.

VII. CONCLUSION

Based upon the foregoing, Claimant Arneson respectfully requests that the Supreme Court enter an Opinion reversing the Circuit Court and affirming the decision of the Department of Labor finding that Arneson's injuries arose out of and in the course and scope of his employment with Employer, that his injury is a major contributing cause of his condition and need for treatment, and that he is permanently and totally disabled under the odd-lot doctrine.

VIII. CERTIFICATE OF COMPLIANCE

Pursuant to SDCL 15-26A-66(b)(4), I certify that Appellant's Brief complies with the type volume limitation provided for in the South Dakota Codified Laws. This Brief contains 9,989 words and 52,054 characters. I have relied on the word and character count of our

processing system used to prepare this Brief. The original Appellant's brief and all copies are in compliance with this rule.

Dated this 22nd day of January, 2024.

BEARDSLEY, JENSEN & LEE,
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on January 22, 2024, he electronically filed a copy of Appellant's Brief with Appendix with the South Dakota Supreme Court through the Odyssey system and that one bound copy of the same was filed by serving by mail upon:

Ms. Shirley A. Jameson-Fergel
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A true and correct copy of *Appellant's Brief* with *Appendix* was also provided by electronic means through the Odyssey system to:

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/s/ Brad J. Lee
Brad J. Lee

APPENDIX

APPENDIX

TABLE OF CONTENTS

CIRCUIT COURT OF SOUTH DAKOTA
SIXTH JUDICIAL CIRCUIT
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October 6, 2023

RE: 32CIV23-84 GR Management LLC, Risk Administration Service Inc. v. Michael Arneson

MEMORANDUM OPINION

GR Management LLC d/b/a Mineral Palace Casino and Risk Administration Service Inc. (collectively referred to as Employer) appeal from a decision of the South Dakota Department of Labor (Department) in favor of Michael Arneson (Arneson). Arneson filed a Petition with Department on July 1, 2019, seeking worker's compensation benefits for an injury that occurred on July 18, 2018. The Department concluded that Arneson's work-related injury was a major contributing cause of Arneson's paroxysmal atrial fibrillation and numbness and sensation issues in his right hand. Further, the Department held that Arneson proved he was permanently and totally disabled and that he made a prima facie showing of entitlement to benefits under the odd-lot category. Finally, the Department held that Arneson was entitled to past disability benefits from February 3, 2020, at his compensation rate of $575.16 per week and that Arneson was entitled to ongoing medical and disability benefits. This Court heard oral arguments on September 25, 2023. After reviewing the administrative record and considering the arguments of the parties, this Court now issues this Memorandum Opinion affirming the Department's decision in part and reversing in part.

FACTS

Arneson was born on August 24, 1955 and was 67 years old at the time of the hearing. In 1972, Arneson left high school to join the United States Navy. He then received his GED. Forty-five days after enlisting in the Navy, Arneson was honorably discharged due to an issue with his eyesight. After his discharge Arneson attended several six-month courses wherein he achieved training in electrical systems, plumbing, machine operation, and swimming pool systems. He received OSHA training and multiple professional certifications. Eventually Arneson earned an Associate degree in finance. Prior to working for Employer, Arneson held a variety of positions. This included work as a machine operator and part technician, over-the-road truck driver, auto repairman, head of maintenance and cleaning of machinery, and maintenance manager.

Beginning September 15, 2015, Arneson started working as the maintenance manager at Mineral Palace. His duties included overseeing maintenance, cleaners, and valet; painting, tiling, carpentry, snow removal, law care, and miscellaneous cleaning; servicing exhaust units, A/C units, and kitchen equipment; and monitoring the plumbing and electrical units.

On July 17, 2018, an electrical storm caused a power outage at the Mineral Place. Arneson surveyed the facility and its equipment. He proceeded to shut off the equipment with the intention to return the next morning to check everything again. On July 18, 2018, Arneson arrived at the Mineral Palace at 6:30 am to assess the damage from the electrical storm. He checked the exhaust fan and then went on the roof to turn off the shunt which cut power to the fan. After checking for shorts in the wires, he turned the breaker on and confirmed all three lines had power. He then went back on the roof to turn the shunt back on. When Arneson touched the shunt, it shorted which caused electrocution to Arneson. Initially, he did not feel anything but shortly after his hand started to tingle. Arneson removed his gloves and observed that the fingers on his right hand were burned.

Following the incident, Arneson went home, showered, washed his right hand with soap and water and then applied an antibiotic ointment to his hand before going to the Lead-Deadwood Emergency Department. While at the Emergency Department, Arneson reported the burns on his hand as well as a hole in his left foot which represented where the electricity exited his body. He also reported a tingly feeling in the fingertips of his right hand. His doctor noted that his hand complaints were likely related to carpal tunnel syndrome. The medical staff performed an electrocardiogram of Arneson's heart which was normal. His heart rate was regular with a normal sinus rhythm. He was sent home with information about electrical injury and burn care. It was recommended that he change his dressings as directed, apply antibiotic ointment, and to take over-the-counter pain relievers.

Two days after the incident, on July 20, 2018, Arneson went to Black Hills Orthopedic reporting that while riding his motorcycle his thumb, index, and middle fingers went number. Dr. Zachary Jager examined Arneson and noted the burns on his fingers were improving. He also discussed with Arneson that the numbness in his middle fingers may be associated with carpal tunnel syndrome. Dr. Jager noted that Arneson did not display any cardiovascular symptoms. Arneson was encouraged to call if his symptoms were not improving, but there is no record he contacted Dr. Jager after that day.

Six days after the incident, on July 24, 2018, Arneson completed and signed an employee injury report. In the report he did not include any references to heart problems following the electrocution. Arneson continued to work at the Mineral Palace. Over the next ten or so days after

the electrocution incident, Arneson began to feel heart palpitations. He was not concerned about the palpitations until July 30, 2018, when he and his co-worker were moving slot machines at the Mineral Palace. Arneson began to experience an episode of supraventricular tachycardia (SVT).[1] He immediately went to the Lead-Deadwood Emergency Department. His heart rate was 195 beats per minute, his blood pressure was 76/48, and he was experiencing chest pain, dizziness, and heart palpitations. Arneson was transferred to the intensive care unit where he was treated for the next two and a half days, by Dr. Mark Ptacek. Dr. Ptacek noted Arneson had no heart issues until July 30, 2018.

Thirteen days after the incident, on July 31, 2018, Arneson was treated by his doctor, Dr. James Holloway. Dr. Holloway diagnosed him as suffering from atrial fibrillation (AFib) and Graves' disease. Atrial fibrillation is an abnormal heart rhythm that commonly causes poor blood flow. Graves' disease is an autoimmune disorder that leads to an overactive thyroid gland (hyperthyroidism). On August 5. 2018, Dr. Holloway informed Arneson that the echocardiogram showed his heart findings were normal and that he believed Arneson would be able to maintain a normal heart rhythm once his hyperthyroidism was under control.

After he was discharged from the hospital, Arneson continued to experience heart palpitations which caused him to feel fatigued. Initially, the AFib occurred approximately four times a day which caused Arneson to rest from a few minutes to half an hour at a time. Arneson's doctors attempted to treat the AFib and episodes of SVT with medications and later by destroying his thyroid. Arneson had not had any episodes of heart palpitations, thyroid issues, or heart issues prior to the electrocution incident on July 18, 2018. There were no medical records indicating heart complaints prior to July 30, 2018. On August 22, 2018, Dr. Holloway confirmed that Arneson had hyperthyroidism and Graves' Disease. A week later, Arneson began medication to treat his hyperthyroidism. Arneson continued to report episodes of AFib, as a result his medication was adjusted on September 26, 2018. By December 10, 2018, Dr. Holloway noted that Arneson's thyroid levels were normal, and there had been no recent episodes of AFib. Arneson also had increased energy levels with no reported unusual tiredness or fatigue. Arneson was advised to contact Dr. Holloway's office if he noticed palpitations or rapid heart rate which were signs of too little hyperthyroid medication. On January 18, 2019, Arneson was provided a heart monitor which monitored his heart rhythm for a continuous 48-hour period. The results were normal, and he reported no symptoms during that time.

Arneson did not report having issues with his heart again until March 7, 2019, when he reported an episode of palpitation that had occurred a few days prior. Arneson had missed two doses of his medication two days prior to the episode. He was advised not to miss doses of his medication. Arneson continued working for Employer full-time until his retirement on June 1, 2019. On April 9, 2019, Dr. Holloway noted the results of CT angiogram performed on Arneson revealed a diffuse nonobstructive 20-30 percent plaque throughout all three of his coronary arteries.

On June 1, 2019, Arneson voluntarily retired, leaving his job at Mineral Palace. At the time of his retirement, Arneson had no medical restrictions. Arneson never requested any accommodation prior to retiring. As maintenance manager Arneson was able to delegate any duties

[1] Supraventricular tachycardia is an irregularly fast or erratic heartbeat that affects the heart's upper chambers.

that he himself could not perform. Arneson was never reprimanded for delegating work to employees or hiring too much work out to contractors. Arneson gained knowledge of Employer's building and its inner workings. He also had extra skills and training than what the job description called for. Arneson testified that these additional skills made him a difficult employee to replace. When Arneson would delegate work, it would go to his employee Brian Ledbetter. Ledbetter testified that after the incident he got more assignment but that he was able to keep up with the workload. Diana Prado, the Assistant General Manager during Arneson's period of employment testified Arneson had resumed his entire normal job duties from July 30, 2018, to the time he retired ten months later on June 1, 2019, and all the work he needed to do was being completed.

Arneson stopped taking his medication on August 16, 2020, because it was causing a rash. His hyperthyroidism was no longer regulated. On September 17, 2020, Arneson visited Dr. Holloway complaining that he was tired. On October 8, 2020, Dr. Holloway noted that Arneson reported his heartbeat would "take off" now and then but did not race. He was placed back on hyperthyroid medicine. On April 21, 2021, Arneson was treated with radioactive iodine therapy which resulted in him developing hypothyroidism. On February 24, 2022, Arneson was seen by Dr. John Palmer who noted that Arneson had suffered an electric shock and subsequently developed significant heart arrhythmias. Dr. Palmer noted that Arneson continued to have frequent heart complaints. Employer denied Arneson's workers' compensation claim on May 10, 2019. Arneson submitted his Petition for Hearing to the Department on June 28, 2019. The Department issued its Decision in favor of Michael Arneson on March 21, 2023. Employer appealed that decision, and the Court enters this Memorandum Decision and Order.

ISSUES

I. **WHETHER THE DEPARTMENT ERRED IN CONCLUDING ARNESON PROVED HIS WORKPLACE INJURY WAS A MAJORY CONTRIBUTING CAUSE OF HIS CONDITION COMPLAINED OF AND NEED FOR TREATMENT BY A PROPERPONDERANCE OF THE EVIDENCE.**

II. **WHETHER THE DEPARTMENT ERRED IN CONCLUDING CLAIMANT PROVED HE IS PERMANETLY AND TOTALLY DISABLE AND IS ENTITLED TO BENEFITS UNDER THE ODD-LOT CATEGORY.**

LEGAL STANDARD

This Court's review of a decision from an administrative agency is governed by SDCL 1-26-36.

> The court shall give great weight to the findings made and inferences drawn by an agency on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

> (1) In violation of constitutional or statutory provisions;
> (2) In excess of the statutory authority of the agency;
> (3) Made upon unlawful procedure;
> (4) Affected by other error of law;
> (5) Clearly erroneous in light of the entire evidence in the record; or
> (6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.
>
> A court shall enter its own findings of fact and conclusions of law or may affirm the findings and conclusions entered by the agency as part of its judgment.

SDCL 1-26-36.

When findings of fact are made based on live testimony, the clearly erroneous standard applies. *See Brown v. Douglas School District*, 2002 SD 92, ¶ 9, 650 N.W.2d 264, 267–68. Deference and great weight are given to the hearing examiner on fact questions. *Id.* at 267. The Department's factual determinations based on documentary evidence, such as depositions, are reviewed de novo. *Hughes v. Dakota Mill and Grain, Inc.*, 2021 S.D. 31, ¶ 12, 959 N.W.2d 903, 907 (further citations omitted). "Whether a claimant makes a prima facie case to establish odd-lot total disability inclusion is a question of fact." *Baker v. Rapid City Reg'l Hosp.*, 2022 S.D. 40, ¶ 29, 978 N.W.2d 368, 378 (quoting *Vollmer v. Wal-Mart Store, Inc.*, 2007 S.D. 25, ¶ 12, 729 N.W.2d 377, 382). However, de novo review is used "when 'an agency makes factual determinations on the basis of documentary evidence, such as depositions' or medical records." *Id.* (citations omitted).

ANALYSIS

I. THE DEPARTMENT ERRED IN PART IN CONCLUDING ARNESON PROVED HIS WORKPLACE INJURY WAS A MAJOR CONTRIBUTING CAUSE OF HIS CONDITION COMPLAINED OF AND NEED FOR TREATMENT BY A PROPERPONDERANCE OF THE EVIDENCE

Arneson must prove by a preponderance of the evidence that he was entitled to worker's compensation benefits. *Darling v. West River Masonry*, Inc., 2010 S.D. 4, ¶ 11, 777 N.W.2d 363, 367. To be awarded benefits, an employee must first establish that he suffered an "injury arising out of and in the course of the employment[.]" Id. See also *Horn v. Dakota Pork*, 2006 SD 5, ¶ 14, 709 N.W.2d 38, 41 ("Our law requires a claimant to establish that his injury arose out of his employment by showing a causal connection between his employment and the injury sustained"). "This causation requirement does not mean that the employee must prove that [his] employment was the proximate, direct, or sole cause of [his] injury; rather the employee must show that [his] employment was a 'contributing factor' to [his] injury." *Orth v. Stoebner & Permann Const.*, Inc., 2006 S.D. 99, ¶ 32, 724 N.W.2d 586, 592-93 (quoting *Brown*, 2002 SD 92, ¶ 19, 650 N.W.2d at 270).

Arneson was not required to prove that the July 18, 2018, injury was at least 50 percent attributable to his condition and need for treatment show that the injury was a major contributing cause of his condition. *Hughes v. Dakota Mill and Grain Inc.*, 2021 S.D. 31, ¶ 20, 959 N.W.2d 903, 909. Nor was Arneson required to prove that the July 18, 2018, injury was *the* major contributing cause of his condition and need for treatment. *Orth,* 2006 S.D. 99, ¶ 41-42, 724 N.W.25 at 595-96 (emphasis added) (citation omitted). Instead, he was required to prove that the July 18, 2018, injury was and remains *a* major contributing cause of his disability, impairment or need for treatment. *Id.* (emphasis added). There is not a magic phrase to express an expert's degree of medical certainty, the test is only whether the expert's words demonstrate that he was expressing an expert medical opinion. *Id.*

Causation must be established by a reasonable degree of medical probability. *Id.* Arneson offered deposition testimony from Dr. Holloway, Arneson's treating physician. Employer offered the deposition testimony of Dr. Brody and live testimony of Dr. Elkins. All but the live testimony of Dr. Elkins was presented by documentary evidence as deposition testimony or medical records, the Court reviews that evidence de novo. *Id.*

A. Medical Causation in Regard to Arneson's Development of Atrial Fibrillation

Employer and Insurer do not dispute that Arneson experienced an electrical shock on July 18, 2018. However, the Department erroneously found that the July 18, 2018, incident was a major contributing cause of Arneson's condition as it related to his AFib. Each of the doctors provided data showing that the development of AFib whether due to electrical shock or hyperthyroidism was uncommon. Dr. Holloway, Dr. Brody, and Dr. Elkins testified that the rate of incidence of the development of AFib due to hyperthyroidism was 10-15 percent. Dr. Elkins testified that he believed that the rate was higher for Arneson based on his age, race, and gender. Each of the experts viewed Arneson's medical records in preparation for their testimony. They also conducted research on AFib, hyperthyroidism, and Grave's disease as Arneson had been diagnosed with each condition.

Dr. Holloway was Arneson's treating physician. Prior to his deposition on September 18, 2020, he reviewed all of Arneson's medical records from Regional Health, Black Hills Orthopedic, and Spine Center, as well as the medical records summary identified as Hearing Exhibit 2. He did not review the opinions of Dr. Brody or Dr. Elkins. Following his deposition, he did not review any additional records or provide an updated opinion. During his deposition Dr. Holloway discussed that the most common injuries that manifest following the passage of an electrical current through the body are related to the heart because the heart is an electrical organ as well as a muscular organ. Dr. Holloway found it significant that Arneson presented with the AFib a short time after having had the electrical injury as it is very common for people to have rhythm disturbances following an electrical injury. Dr. Holloway was unconvinced that Arneson would have developed AFib as a result of his prior condition of hyperthyroidism. He opined that a majority of people with hyperthyroidism do not develop AFib. As noted above, he agreed that roughly only five to fifteen percent of people developed AFib as a result of hyperthyroidism. Prior to July 30, 2018, there was no indication of cardiac symptoms in Arneson's medical records prior to July 18, 2018.

By deposition, Dr. Brody testified that it was most likely that Arneson's AFib was related to his previously asymptomatic hyperthyroidism. Dr. Brody opined that the work event of July 18, 2018, was not a major contributing cause of Mr. Arneson's atrial fibrillation. He also opined that the work event of July 18, 2018, was not a major contributing cause to the hospitalization and heart issues as they presented on July 30, 2018. Arneson was hospitalized on July 30, 2018, because he had atrial fibrillation with a rapid ventricular rate. This occurred twelve days after the electrocution, which was very atypical as he had no arrhythmias at the time of the injury and because he did not have any underlying heart disease. Arneson had no prior history of heart disease, and he has had basically normal echocardiograms. He had a normal EKG immediately after the electrocution, which indicated that there was no evidence that the shock of July 18th caused any structural heart disease that triggered the atrial fibrillation. And Dr. Brody opined that the work event of July 18, 2018, was not a major contributing cause to any of the cardiac issues Mr. Arneson is currently experiencing.

During his deposition Dr Brody explained that atrial fibrillation from electrical shock in and of itself was uncommon. Based on the handful of cases that are in the literature, most cases reported that it occurred at the same time as the shock or the day of the shock. The fact that AFib occurred twelve days later was very unusual. Even though there was somewhat of a chronologic relationship between the shock and the onset of the atrial fib, there was another factor—Mr. Arneson was found to have hyperthyroidism. Dr. Brody found only one article that specifically described some delay in the AFib following an electrical shock. The article commented that the prevalence of atrial fibrillation after an electrical shock was .6 percent. There was a stronger association of atrial fibrillation and hyperthyroidism than the association with electrical shock and atrial fibrillation. Both Dr. Brody and Dr. Holloway testified that there was a 10-15 percent chance of incidence of AFib with hyperthyroidism. Dr. Brody explained that in medicine 10-15 percent was considered to be a fairly common thing. On the other hand, Dr. Brody testified that while AFib itself is common from a cardiologist's standpoint, AFib due to electric shock was uncommon.

Additionally, Dr. Brody testified that if Arneson was feeling heart palpitations in the days following the electrical shock, it was not enough to change his opinion. This was because of Arneson's hyperthyroidism. While Dr. Brody was not aware of any event between July 18th and July 30th, other than the electrical shock, that would cause Mr. Arneson's hyperthyroidism to become symptomatic and cause atrial fibrillation, he would not use the word coincidence. The absence of a specific event did not change Dr. Brody's analysis as there was a well-known (common) association between hyperthyroidism and AFib. This is consistent with the reports that when Arneson's hyperthyroidism was controlled by medication he reported no symptoms of AFib but when he missed doses or stopped his hyperthyroidism medication Arneson reported AFib symptoms.

Dr. Elkins testified live at the hearing. He opined that had Arneson sustained a heart injury from the electrical shock he would have had symptoms of damage within the first 12-24 hours following the incident, but that Arneson did not show signs of damage until his second emergency room visit twelve days later. He agreed that it was common for people who have developed sustained AFib to have brief "transient palpitations" that they ignore and then suffer a full-blown AFib episode. But like Dr. Brody, this did not change his findings that the work

incident was not a major contributing cause to of Arneson's condition. In his research Dr. Elkins found that it was possible for someone to experience arrhythmia days after electrocution and that low-voltage electrocution could cause cardiac injuries. Dr. Elkins testified that there would be, at most, a 1 in 1,000 chance that Claimant's electrical injury cause Arneson's AFib. He agreed with the statistics presented by both Dr. Brody and Dr. Holloway that the odds of an individual with hyperthyroidism developing AFib is roughly 10-15 percent. In fact, he stated that this statistic may not be reflective of Arneson as his age and demographics in conjunction with his hyperthyroidism made him more susceptible to developing AFib than the general public.

The South Dakota Supreme Court has held that a non-treating physician's opinion can be more persuasive than the opinion of a treating physician on causation issues. *Helms v. Lynn's Inc.*, 1996 S.D. 8, 542 N.W.2d 764. Dr. Brody and Dr. Elkins were not treating physicians in this case, they did, however, review Arneson's medical records and reports. The Department found that both Dr. Brody and Dr. Elkins had sufficient foundation for their expert opinions. This Court is persuaded by the findings of Dr. Brody and Dr. Elkins in light of the totality of the circumstances surrounding Arneson's injury, symptoms, and response to medication.

Arneson has the burden of persuasion "by a preponderance of the evidence and that burden is not sustained where the probabilities are equal." *Westergren*, 1996 S.D. 69, ¶ 25, 549 N.W.2d 390, 397. The experts found that there were two possible explanations for Arneson's AFib, hyperthyroidism or electric shock. Each expert agreed that in the general population there is a 10-15 percent chance of hyperthyroidism causing AFib. Dr. Brody found just one case study in the last 70 years where there was a delayed development of AFib following an electric shock. This was less than one percent delayed development of AFib from electric shock. Similarly, Dr. Elkins testified that there was a less than 1 in 1,000 percent chance that Arneson developed AFib as a result of the electric shock. Arneson offered no evidence to counter the testimony of Dr. Brody and Dr. Elkins. While both doctors acknowledged the possibility of Arneson's AFib was caused by the electrocution, a possibility is not sufficient to establish the standard of probability necessary. The probabilities in the case are not equal and as such Arneson has not met his burden by a preponderance of the evidence. The Department erred as a matter of law in determining that the work incident was a major contributing cause of Arneson's AFib.

B. Medical Causation in Regard to Arneson's Right Hand Injury

Both Dr. Holloway and Dr. Brody opined that the work injury was the cause of the numbness Arneson experienced following the electrical shock. Dr. Holloway testified that Arneson had difficulty with fine motor skills, and he could not feel things that he was picking up or touching with his right hand. He also testified that if a damaged nerve was going to recover it usually happened within the first six to twelve months, but it could take up to a couple of years.

Conversely, Dr. Elkins testified that the electrocution was not a major contributing cause of Arneson's hand issues with the possible exception of some fingertip numbness. Dr. Elkins rather opined that Arneson's symptoms were more likely to be the result of carpal tunnel syndrome. Arneson has not been diagnosed with carpal tunnel syndrome.

Following the electric shock, Arneson consistently complained of finger numbness and paresthesia. This Court is persuaded by the testimony of Dr. Holloway and Dr. Brody and agrees

with the Department that the electrical injury was a major contributing cause of Arneson's right-hand injury.

II. THE DEPARTMENT ERRED IN CONCLUDING CLAIMANT PROVED HE WAS PERMANETLY AND TOTALLY DISABLED AND WAS ENTITLED TO BENEFITS UNDER THE ODD-LOT CATEGORY.

A claimant has presented a prima facie showing to warrant permanent total disability under SDCL 62-4-53 when the claimant shows evidence that: "(1) claimant is obviously unemployable due to his or her physical condition, coupled with his or her age, training and experience, or (2) [of the] unavailability of suitable employment by showing that he or she has made reasonable efforts to find work and was unsuccessful." *Rapid City Reg'l Hosp.*, 978 N.W.2d at 378. If a claimant makes a prima facie showing under either prong one or prong two, "the burden of production shifts to the employer to show that some suitable employment within claimant's limitations is actually available in the community." *Id.* at ¶32 (citations omitted). If a claimant fails to show obvious unemployability, the claimant bears the burden of presenting evidence of "the unavailability of suitable employment" which may be done "by showing that he has made reasonable efforts to find work and was unsuccessful." *Id.* "The burden will only shift to the employer in the second alternative when the claimant produces substantial evidence that he is not employable in the competitive market." *Id.* If the burden does shift to the employer, the employer must "show that some form of suitable work is regularly and continuously available." *Id.* Though the burden may shift between the parties, the claimant bears the ultimate burden of persuasion. *Id.* As a matter of law, "the effort to seek employment is not reasonable if the employee places undue limitations on the kind of work the employee will accept or *purposefully leaves the labor market.* An employee shall introduce expert opinion evidence that the employee is unable to benefit from vocational rehabilitation or that the same is not feasible." SDCL 62-4-53 (emphasis added).

The Department found that Arneson had an excellent work history and a degree in finance that made him marketable for sedentary-type work. The Department also found that Arneson continued to work full-time for Employer for over ten months after the accident at which time he voluntarily retired. Arneson was never reprimanded at work for delegating too much work to employees and was, in fact, encouraged to do so more often. At the time of his retirement, Arneson had been able to perform his job satisfactorily without any medial restrictions and had not requested any accommodations. Despite stating that it was unable to conclude that Arneson was permanently and totally disabled at the time that Arneson voluntarily and purposefully left the labor market by retiring, the Department concluded that Arneson is now entitled to benefits under the odd-lot category.

The Department came to this conclusion contrary to the findings made. The Department found that during Arneson's supervisor Diana Prado believed Arneson was a good, reliable worker whose knowledge she considered a valuable asset. That prior to his retirement, Arneson had been delegating more to other staff which was something that he had been previously encouraged to do more often. Most significantly, Prado stated that Arneson was eligible for rehire. Employer did not approach Arneson for rehire because he retired and believed he did not want to work full time. In *McClaflin v. John Morell & Co.*, the South Dakota Supreme Court held that the claimant failed to

make a prima facie showing for benefits under the odd-lot category as he was able to perform work for his employer. The court emphasized that under the workers' compensation jurisprudence there was not "competitive market" test. The Supreme Court reversed the circuit court, finding that the Claimant was not entitled to PTD benefits as he was able to work within his restrictions for his employer. The Department found that Arneson was eligible for rehire with Employer and that Employer would have been willing to address accommodations that Arneson may have needed. Arneson was not "obviously unemployable" or permanently and totally disable but rather voluntarily left the job market. His failure to return to his position cannot sustain an award.

CONCLUSION

The Department's conclusion that the work-related electric shock incident was and a major contributing cause of Arneson's right hand injuries was not in error. However, the Department erred in finding the work incident was a major contributing cause of Arneson's AFib. The Department also erred in awarding odd lot benefits. As such the decision of the Department is affirmed in part and reversed and remanded in part. An Order shall be entered consistent with this decision.

Dated this 6th day of October 2023.

BY THE COURT

Christina Klinger

Christina Klinger
Circuit Court Judge

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	) SS	
COUNTY OF HUGHES	)	SIXTH JUDICIAL CIRCUIT

MICHAEL ARNESON,	)	
	)	32CIV23-84
Claimant-Appellee,	)	
v.	)	
	)	**ORDER**
GR MANAGEMENT LLC,	)	
	)	
Employer-Appellant	)	
	)	
and	)	
	)	
RISK ADMINISTRATION SERVICE INC,	)	
	)	
Insurer-Appellant.	)	

WHEREAS, the Court having entered its Memorandum Decision on October 6, 2023, and having expressly incorporated the same herein, it is hereby

ORDERED, ADJUDGED, AND DECREED:

The South Dakota Department of Labor's decision concluding that Michael Arneson proved his work-related injury was and remained a major contributing cause of his atrial fibrillation condition and need for medical treatment is REVERESED and REMANDED. The Department's decision concluding that Michael Arneson proved his work-related injury was and remained a major contributing cause of his right-hand injury and need for medical treatment is AFFIRMED. The Department's concluding Arneson proved he is permanently and totally disabled and entitled to benefits under the odd-lot category is REVERSED and REMANDED.

Pursuant to SDCL 1-26-32.1 and SDCL 15-6-52(a), the Court's Memorandum Decision shall act as the Court's findings of fact and conclusions of law as permitted by SDCL 1-26-36.

Dated this 6th day of October 2023.

BY THE COURT:

Christina Klinger

The Honorable Christina L. Klinger
Circuit Court Judge
Sixth Judicial Circuit

Attest:
Deuter-Cross, TaraJo
Clerk/Deputy

SOUTH DAKOTA DEPARTMENT OF LABOR & REGULATION
DIVISION OF LABOR AND MANAGEMENT

MICHAEL ARNESON **HF No. 1, 2019/20**

Claimant,

v. **DECISION**

GR MANAGEMENT, LLC, d/b/a
MINERAL PALACE CASINO.
Employer,

and

RISK ADMINISTRATION SERVICES,

Insurer.

This is a workers' compensation case brought before the South Dakota Department of Labor & Regulation, Division of Labor and Management pursuant to SDCL § 62-7-12 and ARSD 47:03:01. The case was heard by Michelle M. Faw, Administrative Law Judge, on September 14, 2022. Claimant, Michael Arneson, was present and represented by Brad J. Lee, Connor Casey, and Michael S. Beardsley of Beardsley, Jensen, & Lee. Employer and Self-insurer were represented by Charles A. Larson of Boyce Law Firm.

Facts:

Based upon the evidence presented and live testimony at hearing, the following facts have been established by a preponderance of the evidence:

Michael Arneson (Arneson) was born on August 24, 1955. In 1972, Arneson left school to join the United States Navy. He received his GED. 45 Days after enlisting in the Navy, he was honorably discharged due to an issue with his eyesight. He then attended

several six-month courses wherein he achieved training in electrical systems, plumbing, machine operation, and swimming pool systems. He received OSHA training and received multiple professional certifications. Arneson also earned an Associate degree in finance. Arneson applies his education to various occupations.

- From 1974 to 1989, Arneson worked at Atlas Mill as a machine operator and part technician.
- From 1989 to 1991, Arneson worked for Dusheck Trucking as an over-the-road truck driver.
- From 1991 to 2006, Arneson started his own business called Arnie's All Season Repair and Arneson Engine Rebuilders where he rebuilt engines and performed auto repair.
- From 2006 to 2014, Arneson worked for Harley Davidson as head of maintenance and cleaning of machinery.
- From 2014 to 2015, Arneson worked for Rivers Hotel Group as the maintenance manager.

On September 15, 2015, Arneson began working as the maintenance manager for GR Management, LLC, d/b/a Mineral Palace Casino (Employer) which was at all times pertinent to this matter insured for workers' compensation purposes by Risk Administration Services (jointly, Employer and Insurer). His duties included overseeing maintenance personnel, cleaners, and valet; painting, tiling, carpentry, snow removal, lawn care, and miscellaneous cleaning; servicing exhaust units, A/C units, and kitchen equipment; and also monitoring the plumbing and electrical units.

On July 17, 2018, an electrical storm caused a power outage at the Mineral Palace. Arneson checked out the facility and its equipment. He then shut off the equipment with the plan to return in the morning to check everything again. The next morning, on July 18, 2018, Arneson arrived at the Mineral Palace at 6:30 a.m. to assess the damage from the electrical storm. He checked the exhaust fan and then went on the roof to turn off the shunt which cuts power to the fan. After checking there were no shorts in the wires, he turned the breaker on and confirmed all three lines had power. He then went back on the roof to turn the shunt back on. When Arneson touched the shunt, it shorted which caused electrocution. Initially, he did not feel anything but shortly after his hand started to tingle. He removed his gloves and observed that his fingers were burned on his right hand.

Arneson went home, showered, washed his right hand with soap and water, and then applied an antibiotic ointment to his hand before going to the Lead-Deadwood Emergency Department. At the Emergency Department, he reported the burns on his hand as well as a hole in his left foot which represented where the electricity exited his body. He also reported a tingly feeling in the fingertips of his right hand. His doctor noted that his hand complaints were likely to be related to carpal tunnel syndrome. The medical staff performed an electrocardiogram of Arneson's heart which was normal. His heart rate was regular with a normal sinus rhythm. He was sent home with information about electrical injury and burn care, and it was recommended that he change his dressings as directed, apply antibiotic ointment, and to take over-the-counter pain relievers.

On July 20, 2018, Arneson went to Black Hills Orthopedic reporting that he was riding his motorcycle and his thumb, index, and middle fingers went numb. Dr. Zachary Jager examined Arneson and noted the burns on his fingers were improving. He also

discussed with Arneson that the numbness in his middle fingers may be associated with carpal tunnel syndrome. Dr. Jager noted that Arneson did not display any cardiovascular symptoms. Arneson was encouraged to call if his symptoms were not improving, but there was no record he contacted Dr. Jager after that day.

Arneson completed and signed an employee injury report on July 24, 2018. The report did not include any references to heart problems after the electrocution.

Arneson continued to work at the Mineral Palace. Over the next ten or so days after the electrocution incident, he began to feel heart palpitations. He was not concerned about the palpitations until July 30, 2018, when he and his co-worker were moving slot machines at the Mineral Palace. Arneson experienced an episode of supraventricular tachycardia (SVT).

Arneson immediately went to the Lead-Deadwood Emergency Department. His heart rate was 195 beats per minute, blood pressure was only 76/48, and he was experiencing chest pain, dizziness, and heart palpitations. Arneson was then sent to the intensive care unit (ICU) where he was treated for the next two and a half days. Arneson was treated by Dr. Mark Ptacek who noted Arneson had no heart issues until July 30, 2018. Dr. Ptacek noted that the context provided by Arneson for his condition was caffeine.

On July 31, 2018, Arneson was treated by his doctor, Dr. James Holloway, who diagnosed him as suffering from atrial fibrillation (AFib) and hyperthyroidism. Dr. Holloway wrote to Arneson on August 5, 2018, informing him that the echocardiogram showed Arneson's heart findings were normal, and he was encouraged that Arneson would be able to maintain a normal heart rhythm once his hyperthyroidism was under control.

After being discharged from the hospital, Arneson continued to experience heart palpitations which caused him to feel fatigued. At first, the AFib occurred approximately four times a day which caused Arneson to require rest from a few minutes to half an hour. Arneson's doctors attempted to treat the AFib and episodes of SVT with medications and by destroying his thyroid without success. Arneson had not had any episodes of heart palpitations, thyroid issues, or heart issues prior to the electrocution incident on July 18, 2018. There were no medical records indicating heart complaints prior to July 30, 2018.

On August 22, 2018, Dr. Holloway confirmed that Arneson had hyperthyroidism and Graves' Disease. A week later, he started Arneson on medication to treat hyperthyroidism. Arneson continued to report episodes of AFib and so his medication was adjusted on September 26, 2018. By December 10, 2018, Dr. Holloway noted that Arneson's thyroid levels were normal, and there had been no recent episodes of AFib. Arneson also had increased energy levels and reported no unusual tiredness or fatigue. He was advised to contact the office if he noticed palpitations or rapid heart rate which were signs of too little hyperthyroid medication.

On January 18, 2019, Arneson was provided a heart monitor which monitored his heart rhythm for a continuous 48-hour period. The results were normal, and he reported no symptoms during that time. He did not report having issues with his heart again until March 7, 2019, when he reported an episode of palpitation that had occurred a few days prior. He stated that he had missed his medication two days prior to the episode. He was advised not to miss doses of his medication.

On June 1, 2019, Arneson left his job at Mineral Palace because of the AFib, fatigue, and right-hand numbness led him to conclude he could no longer perform his job

duties. On April 9, 2019, Dr. Holloway noted the results of a Ct Angiogram performed on Arneson revealed a diffuse nonobstructive 20-30% plague throughout all three of his coronary arteries.

On September 17, 2020, Arneson visited Dr. Holloway complaining that he was tired. He stopped taking his medication on August 16, 2020, because they were causing a rash. His hyperthyroidism was no longer regulated. On October 8, 2020, Dr. Holloway noted that Arneson reported his heartbeat would "take off" now and then but did not race. He was back on hyperthyroid medicine. His heart sometimes skipped beats later in the evening, but he did not experience a rapid heart rate. On April 21, 2021, Arneson was treated with radioactive iodine therapy which caused him to develop hypothyroidism instead of hyperthyroidism. On February 24, 2022, Arneson was seen by Dr. John Palmer who noted that he had suffered an electric shock and subsequently developed significant heart arrhythmias. Dr. Palmer noted that Arneson continued to have frequent heart complaints.

Employer and Insurer denied Arneson's workers' compensation claim on May 10, 2019. Arneson submitted his Petition for Hearing to the Department of Labor & Regulation on June 28, 2019.

Other facts will be determined as necessary.

Issues:

The issues presented at the hearing were

1. Nature and extent of injury;
2. Major contributing cause; and
3. Permanent total disability

Nature and Extent of Injury and Major Contributing Cause:

To prevail in this matter, Arneson must first prove that his work-related injury is a major contributing cause of his condition. SDCL § 62-1-1(7) provides, in pertinent part:

> "Injury" or "personal injury," only injury arising out of and in the course of the employment, and does not include a disease in any form except as it results from the injury. An injury is compensable only if it is established by medical evidence, subject to the following conditions:
> (a) No injury is compensable unless the employment or employment related activities are a major contributing cause of the condition complained of; or
> (b) If the injury combines with a preexisting disease or condition to cause or prolong disability, impairment, or need for treatment, the condition complained of is compensable if the employment or employment related injury is and remains a major contributing cause of the disability, impairment, or need for treatment;

Arneson is "not required to prove his employer was the proximate, direct, or sole cause of his injury." *Smith v. Stan Houston Equip. Co.*, 2013 S.D. 65, ¶ 16, 836 N.W.2d 647, 652. He must prove "that employment or employment-related activities [are] a major contributing cause of the condition of which [he] complained, or, in cases of preexisting disease or condition, that employment or employment-related injury is and remains a major contributing cause of the disability, impairment, or need for treatment." *Norton v. Deuel School Dist. No. 19-4*, 674 N.W.2d 518, 521 (S.D. 2004). "The fact that an employee may have suffered a work-related injury does not automatically establish entitlement to benefits for his current claimed condition." *McQuay v. Fischer Furniture*, 2011 S.D. 91, ¶ 11 808 N.W.2d 107, 111 (citations omitted). The standard of proof for causation in a worker's compensation claim is a preponderance of the evidence. *Armstrong v. Longview Farms, LLP,* 2020 S.D. 1, ¶ 21, 938 N.W.2d 425, 430. "The testimony of professionals is crucial in establishing this causal relationship because the field is one in which laymen ordinarily are unqualified to express an opinion." *Day v.*

John Morrell & Co., 490 N.W.2d 720, 724 (S.D. 1992). Arneson has offered the opinions of Dr. Holloway. Employer and Insurer have offered the opinions of Dr. Brody and Dr. Elkins. The medical experts opined on Arneson's AFib, fatigue, and hand issues. The Department will address the issue of the AFib first.

Dr. Holloway

Dr. Holloway graduated from Indiana University Medical School in 1979. He performed an internal medicine residency for the next three years then did a two-year internal medicine fellowship at Johns Hopkins. Dr. Holloway has been a practicing internist at the Deadwood Regional Medical Clinic from 1992 to the present.

Dr. Holloway has been Arneson's primary treating doctor following his electrocution. Prior to his deposition on September 18, 2020, he reviewed all of Arneson's medical records from Regional Health, Black Hills Orthopedic, and Spine Center, as well as the medical records summary identified as Hearing Exhibit 2. At his deposition, Dr. Holloway was asked if he had conducted any independent research related to electrical injuries and AFib. He answered that he had reviewed an online resource called UpToDate Textbooks on Cardiology. He specifically mentioned that he researched electrical injury and cardiac arrhythmias as well as the relationship between thyroid conditions and cardiac arrhythmias including AFib. Dr. Holloway opined that the electrical work injury suffered by Arneson was a major contributing cause of his AFib.

At his deposition, Dr. Holloway also reviewed a form regarding electric shock injury that Arneson was provided when he was discharged from the Lead-Deadwood Emergency Department. The form specifically mentioned that a strong electric shock could harm the heart. It specifically listed the following symptoms: tingling and numbness, very bad pain; skin burns, chest pain; and very fast irregular heartbeat. Dr.

Holloway discussed how the most common injuries that manifest following the passage of an electrical current through the body, are related to the heart because the heart is an electrical organ as well as a muscular organ. He testified that most serious electrical shock injuries occur with a voltage over 600 volts. He also testified that any time there is a passage of electrical current through the body it can cause damage to the cells it passes through. He stated that cellular damage caused by the electrical current can often cause long-term lasting effects. Dr. Holloway provided that he did not know the type of current Arneson was exposed to or the duration of that exposure. Dr. Holloway found it significant that Arneson presented with the AFib a short time after having had the electrical injury. He stated it was very common for people to have rhythm disturbances after an electrical injury. Dr. Holloway testified that AFib may cause issues with dizziness, lightheadedness, and inability to stand. People can get very dizzy or even collapse with AFib.

Dr. Holloway was also asked to discuss the relationship between the work injury and Arneson's thyroid condition. He stated that the thyroid issue was not related to the electrical injury. He also stated that hyperthyroidism is a predisposing factor for the development of AFib, but only about 5 to 15 percent of patients with hyperthyroidism develop AFib. Further, he testified that thyroid issues often present quickly because a person reaches a certain threshold where symptoms occur.

He further testified that he was unaware of any data that would give a specific time for AFib to occur following a shock. He stated that he would not consider AFib occurring a year later to be related, but weeks to a few months afterward, he would probably attribute the AFib at least in a large part to the shock. He opined that it was more likely than not that Arneson would not have developed AFib without the electric

shock, because the majority of people with hyperthyroidism do not develop AFib. Dr. Holloway testified that the fact that Arneson smokes a pack of cigarettes a day probably increased his risk of AFib. Dr. Holloway has not reviewed Arneson's recent medical records since his deposition, and he has not reviewed Dr. Elkins' or Dr. Brody's opinions. Employer and Insurer contend that Dr. Holloway's understanding of the mechanism of injury is flawed because he has mistakenly assumed that Arneson experienced a high-voltage electrical shock. However, Dr. Holloway testified that he did not know the specific voltage or duration of the shock, but he presumed the type of current Arneson was exposed to be a standard outlet with AC current such as would be in a home. Thus, it is not clear from his testimony that he assumed it was high voltage.

Dr. Brody

Dr. Brody attended medical school at the University of Minnesota graduating in 1983. He then attended an internal medicine internship at the New England Deaconess Hospital in Boston, Massachusetts for one year. He became a resident of internal medicine at Hennepin County Medical Center at the University of Minnesota for two years and then attended a fellowship in cardiovascular medicine at the West Roxbury VA in Boston for two years. He returned to Hennepin County Medical Center for a cardiology fellowship. Dr. Brody then practiced cardiology in St. Paul, Minnesota. He is also board certified in internal medicine and cardiology.

Dr. Brody performed a review of Arneson's medical records on March 20, 2020. He was also provided supplemental records and was deposed on January 6, 2021. At deposition, Dr. Brody answered no to questions regarding whether he considered himself an expert in treating and testifying about thyroid problems or individuals that had hyperthyroidism that had been subject to electrical shock. Dr. Brody testified at

deposition that he was very familiar with AFib and that of the 100 patients he had seen in the last two months, 32 had AFib. He also stated he was familiar with the issues that can occur with the heart after an electrical shock.

Regarding the July 18, 2018, work-related injury, Dr. Brody addressed the records from the emergency department which did not note abnormal findings or indicate an injury to Arneson's heart. Arneson's EKG was normal which indicated to Dr. Brody that there was no evidence the electrical shock caused structural damage to his heart. Dr. Brody concluded that the electrical shock Arneson experienced was not a major contributing cause of the AFib. He based his opinion on two factors: (1) AFib generally occurs on the same day as the electrical injury; and (2) there are essentially no reports of an association of AFib occurring 12 days after an electrical injury in his research or in his experience as a treating physician. Dr. Brody looked at the results of Arneson's EKG and found that it was normal. He also reviewed Arneson's medical records and found no indication of cardiac symptoms prior to July 30, 2018. He stated there was no evidence that the electrical shock caused any structural heart disease that triggered AFib.

Dr. Brody testified that it may be possible for an electrical injury to cause AFib, but he has seen less than five cases of it happening in his forty years of practice. He also stated that based on his research AFib after the electrical shock was very rare. One study he reviewed stated a .6% chance of getting AFib from an electrical shock. Although, he did find an article concerning a patient who suffered a low-voltage shock and then developed AFib six weeks after the event. Dr. Brody was also asked about hyperthyroidism and AFib. He considered the 10 to 15 percent chance of AFib with hyperthyroidism to be a fairly common thing in medicine. He testified that it was most

likely that Arneson had hyperthyroidism prior to the July 18 incident, and he did not have symptoms or AFib prior to the electrocution. He did not know what caused Arneson's hypothyroidism to become symptomatic and caused him to go into AFib.

Dr. Elkins

Dr. Elkins graduated medical school in 1993 at the University of Wisconsin. He then performed a preventative medicine residence at the Loma Linda University Medical Center and was selected as chief resident. He is board certified in occupational medicine and was board certified in preventative medicine. Dr. Elkins practice occupational medicine in Bettendorf, Iowa until he became Medical Director for Occupational medicine at Avera in Sioux Falls, SD in 2004. He practiced at Avera for 12 years. He currently practiced at the Sioux Falls VA hospital and Elkins Medical Services.

Dr. Elkins testified live at the hearing. Dr. Elkins performed a review of all Arneson's available medical records. He also reviewed the depositions of both Dr. Holloway and Dr. Brody. To aid him in forming his opinion, he also researched Graves' Disease, hyperthyroidism, electrical shock injuries, and the incidence of arrhythmias caused by both hyperthyroidism and electrical injuries. He produced three medical record review reports, and all his opinions were provided within a reasonable degree of medical certainty or probability.

He testified that the shock Arneson experienced was DC current, and DC current is less medically destructive than AC current. He opined that had Arneson sustained a heart injury from the electrical shock, he would have had symptoms of damage within the first 12-24 hours following the incident, but he did not show signs of damage or

arrhythmia until twelve days later. He further agreed upon questioning that it was common for people who have developed sustained AFib to have brief "transient palpitations" that they ignore, but then suffer a full-blown AFib episode. (HT 273:20-274:7[1]). Dr. Elkins testified that suffering from Graves' Disease, along with his age and that he is a white male made Arneson more likely to develop AFib. He added that Arneson's history as a smoker increased his risk. He further opined that most electrical shock injuries causing serious damage to the body require greater than 600 volts and the shock Arneson received 440 volts. In his opinion, the electrocution was not a major contributing cause of Arneson's condition, need for treatment, or need for work restrictions. He also stated that it was possible that somebody could experience arrhythmia days after electrocution. He also agreed that an article he referenced to prepare his opinion showed that low-voltage electrocution could cause cardiac injuries. He further conceded that prior to the electrocution, Arneson's hyperthyroidism and Graves' disease were asymptomatic. He also testified that Arneson's condition was worsening, and the reason was unknown.

At hearing, Dr. Elkins was asked a series of questions about his expertise. He answered that he did not consider himself an expert in treating patients with AFib, Graves' Disease, thyroid problems, or cardiac problems. He was also asked if he had special training in these areas or whether he treated thyroid problems on a continuing basis. His answer indicated that he did not. Arneson contends that due to his lack of expertise in these specific areas, Dr. Elkins is not qualified to testify whether Arneson's injuries were caused by the electrocution.

[1] References to the hearing transcript will be indicated with "HT".

Analysis:

The Department will first address whether the experts' opinions are supported by the necessary foundation. "The value of the opinion of an expert witness is no better than the facts upon which they are based. It cannot rise above its foundation and proves nothing if its factual basis is not true." *Schneider v. S. Dakota Dep't of Transp.*, 2001 S.D. 70, ¶ 16, 628 N.W.2d 725, 730 (citations omitted). Dr. Holloway is Arneson's treating physician and he reviewed medical records prior to his deposition. He has not reviewed records since his deposition or provided an updated opinion. The South Dakota Supreme Court (Court) has clarified that experts are not "required to consider all of a claimant's medical records to establish an adequate foundation for their opinions." *News Am. Mktg. v. Schoon*, 2022 S.D. 79, ¶ 38, 984 N.W.2d 127, 138–39. The Department concludes that Dr. Holloway's opinion is based on adequate foundation.

Dr. Brody and Dr. Elkins are not treating physicians, but they have reviewed Arneson's medical records and reports. The Court has held that a non-treating physician's opinion can be more persuasive than the opinion of a treating physician on causation issues. *Helms v. Lynn's Inc.*, 1996 S.D. 8, 542 N.W. 2d 764. Both doctors have sufficient foundation for their opinions.

The Court has held that causation must be proven to "a reasonable degree of medical probability, not just possibility." *Jewett v. Real Tuff, Inc.*, 2011 S.D. 33, ¶ 23, 800 N.W. 2d 345, 350. The data provided by the doctors shows that developing AFib whether due to electrical shock or hyperthyroidism is uncommon. Arneson developed an uncommon condition and the question before the department is whether it is probable that the electrical shock he experienced on July 18, 2018, was a major

contributing cause of that condition. Having reviewed the record and the doctors' opinions, the Department finds that it is probable that the electric shock experienced by Arneson is a major contributing cause of his development of AFib and his current condition.

Dr. Brody and Dr. Elkins opined that it was very rare for AFib to be caused by an electrical shock and had the injury caused the AFib, the symptoms would have appeared soon after the shock. However, both doctors testified that there have been cases of AFib after an electrical shock and cases where an individual's shock related AFib developed later. Regarding the development of Arneson's palpitations, Employer and Insurer point to an employee injury report completed and signed by Arneson on July 24, 2018. The report required Arneson to note all injuries he received from the accident on July 18, 2018. He did not include any references to heart concerns. Arneson testified at the hearing that he was experiencing minor palpitations for the first couple of days following the shock but considered them to be a "fluke." (HT 29:22). Dr. Holloway opined that it was not uncommon for people to disregard those kinds of brief palpitations. He also testified that he had witnessed Arneson minimizing symptoms and failing to report conditions or problems such as when he developed a rash due to a medication. Dr. Elkins also confirmed that it was common for individuals to develop transient palpitations that they ignore. The Department finds Arneson's testimony to be credible and believes that he did experience palpitations that he disregarded until they became serious enough that he went to the emergency department on July 30, 2018.

While Arneson has multiple conditions, traits, and habits that increase the likelihood he would develop AFib such as Graves' disease, his smoking habit, and that

he is a white male, the Department finds that the electrical shock he experienced was a major contributing cause. The Court has held that a work incident does not need to be "the" major contributing cause but need only be "a" major contributing cause. *Hughes v. Dakota Mill Grain, Inc. and Hartford Insurance*, 2021 S.D. 31, ¶ 22, 959 N.W.2d 903. Dr. Holloway testified that the most common injuries following an electrical injury are to the heart and such injuries can cause long-term effects. Additionally, he considered the fact Arneson developed heart palpitations within a short time period significant. The Department is persuaded by Dr. Holloway's analysis and his conclusion that it is more likely than not that Arneson developed AFib as a result of the electric shock. Thus, the Department is persuaded that the electrical injury Arneson sustained is a major contributing cause of his current condition.

The Department will next address the issue of Arneson's hand injury. Dr. Holloway opined that the numbness was not the same as it was when it first started, but it was still present. He further testified that Arneson had recovered some function, and his numbness is present but not as bad as it had been when it first started. Dr. Holloway mentioned that Arneson has difficulty with fine motor skills, and he cannot feel things that he is picking up or touching with his dominant hand. This can result in breaking things in the hand. He further stated that Arneson is more likely to drop things due to his lack of feeling. He had observed that Arneson grabs things differently than most people. Specifically, he will not use the tip of his thumb to grab things because he cannot feel it so he uses the thumb joint. Dr. Holloway testified that this could result in future arthritic problems. Arneson is also unable to feel hot and cold well. Dr. Holloway opined that the reduced sense of pain in his hand could result in injury because he would not recognize

pain immediately and could sustain a serious injury due to the lack of sensation. He testified that if a damaged nerve is going to recover, it usually happens within the first six to twelve months, but it can take up to a couple of years. Arneson has experienced partial recovery, but he still has limitations.

Dr. Brody was asked whether he agreed that the work injury was the cause of the numbness Arneson was experiencing after the electrical shock, and he agreed that it was. Dr. Elkins opined that the electrocution was not a major contributing cause of Arneson's hand issue with the possible exception of some fingertip numbness. He stated that Arneson's hand symptoms are inconsistent with electrical injury and his current symptoms are different than what he presented with at the time of the incident. He also testified that Arneson was able to work and ride his motorcycle cross-country following the incident, but he now complains of incoordination which was not present in the days, weeks, and months after the injury. Dr. Elkins opined that Arneson's worsening symptoms cannot be explained by an electrical injury. Dr. Elkins mentioned the possibility of carpal tunnel syndrome due to the distribution of the numbness in Arneson's hand. Arneson has not been diagnosed with carpal tunnel syndrome. He also opined that Arneson did not complain of incoordination initially and that when symptoms change over time the diagnosis should be reconsidered.

The Department is persuaded by Dr. Holloway's testimony that the electrical shock injury is a major contributing cause of Arneson's ongoing issues with numbness and sensation in his right hand. It appears that the electrical shock caused nerve damage that has only partially healed and as of the time of the hearing, he was still experiencing significant issues with his hand. Additionally, the medical record shows

that Arneson has consistently complained of finger numbness and paresthesia since the injury. The electrical injury is a major contributing cause of Arneson's right-hand issues.

Permanent and Total Disability:

To make a prima facie showing that he is entitled to odd-lot benefits, Arneson must prove either that due to his physical condition, coupled with his education, training, and age, it is obvious that he is obviously unemployable, or 2) that he is in the kind of continuous severe and debilitating pain which he claims. *Eite v. Rapid City Area Sch. Dist. 51-4*, 2007 SD 95, ¶21, 739 N.W.2d 264, 270-71. (citations omitted). SDCL 62-4-53 provides

> An employee is permanently totally disabled if the employee's physical condition, in combination with the employee's age, training, and experience and the type of work available in the employee's community, cause the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income.
>
> An employee has the burden of proof to make a prima facie showing of permanent total disability. The burden then shifts to the employer to show that some form of suitable work is regularly and continuously available to the employee in the community. The employer may meet this burden by showing that a position is available which is not sporadic employment resulting in an insubstantial income as defined in subdivision 62-4-52(2). An employee shall introduce evidence of a reasonable, good faith work search effort unless the medical or vocational findings show such efforts would be futile. The effort to seek employment is not reasonable if the employee places undue limitations on the kind of work the employee will accept or purposefully leaves the labor market. An employee shall introduce expert opinion evidence that the employee is unable to benefit from vocational rehabilitation or that the same is not feasible.

SDCL 62-4-52 defines "sporadic employment resulting in an insubstantial income," as:

> employment that does not offer an employee the opportunity to work either full-time or part-time and pay wages equivalent to, or greater than, the workers' compensation benefit rate applicable to the employee at the time of the employee's injury. Commission or piece-work pay may or may not be considered sporadic employment depending upon the facts of the individual situation. If a bona fide position is available that has essential functions that

> the injured employee can perform, with or without reasonable accommodations, and offers the employee the opportunity to work either full-time or part-time and pays wages equivalent to, or greater than, the workers' compensation benefit rate applicable to the employee at the time of the employee's injury the employment is not sporadic. The department shall retain jurisdiction over disputes arising under this provision to ensure that any such position is suitable when compared to the employee's former job and that such employment is regularly and continuously available to the employee.

The Court has provided two ways a claimant can make a prima facie showing of entitlement to benefits under the odd-lot category. "(1) claimant is obviously unemployable due to his or her physical condition, coupled with his or her age, training, and experience, or (2) unavailability of suitable employment by showing that he or she has made reasonable efforts to find work and was unsuccessful." *Billman v. Clarke Mach., Inc.*, 2021 S.D. 18, ¶ 25, 956 N.W.2d 812, 820.

Age, Training, and Experience

Arneson asserts that he is permanently and totally disabled, obviously unemployable and that his physical condition, education, training, and age place him in the odd-lot total disability category. He was born in 1955 and as of the time of the hearing was 67 years old. He received his GED, and his work history has mainly been hands-on maintenance work, over-the-road trucking, and mechanical repair. He also has an Associate of Arts degree in finance but none of his past jobs have applied the degree.

Employer and Insurer contend that Arneson is not obviously unemployable and his skills as a supervisor are extremely marketable, uncommon, and easily transferrable to different employment opportunities. Additionally, he has an excellent work history and a degree in finance that makes him marketable for sedentary-type work. Arneson also

has a number of licenses including electrical, plumbing, and federal MACS. Arneson continued to work full-time for Employer for over ten months after the accident at which time he voluntarily retired. At the time of his retirement, he had no medical restrictions and he had not requested an accommodation. Arneson testified that he had employees that could help him with certain duties such as heavy work with which he struggled. He was not reprimanded at work for delegating too much to employees and was, in fact, encouraged to do so more often. Employer and Insurer assert these facts indicate that he would have been able to continue in his position as a supervisor. His manager, Diana Prado (Prado), testified that prior to his retirement, Arneson's performance was between good and exceptional for 2018.

Since retiring, Arneson has performed mechanical work on vehicles belonging to his wife or friends. He testified he is able to work on projects using his right hand including working on vehicles and motorcycles. He was also able to help his friends move. At one point, he was able to ride his motorcycle on a trip lasting 15 hours.

Physical Condition

Arneson has offered the expert vocational opinion of Tom Audet. Audet spoke with Arneson regarding his limitations and produced a Physical Capacities Form. Audet then asked Dr. Holloway to review the form and sign it if he agreed. The Physical Capacities Form, as signed by Dr. Holloway, reflects Arneson's abilities regarding his right hand as occasional handling, feeling, firm grasping, and pushing or pulling. It further indicates that Arneson can never perform fine finger manipulation or light grasping and that Arneson is able to occasionally bend, squat, kneel, or climb. Arneson's lack of sensation results in an inability to detect heat and cold. Due to the

AFib and his medications, Arneson is at risk while using dangerous machinery. Additionally, Dr. Holloway testified that Arneson could work an eight-hour day if it was within his other restrictions. He also stated if Arneson experiences AFib he has to stop and rest for between five and twenty minutes and it typically occurs three to four times per week. He further testified that on the Physical Capacities Form, the noted limitations regarding standing/ walking and sitting were referring more to individuals in general and not Arneson specifically. Additionally, the medical record shows multiple instances of Arneson reporting experiencing fatigue. Employer and Insurer provided the expert vocational opinion of Jim Carrol who asserted that it was inappropriate for Audet to fill out the form and have Dr. Holloway sign it. He testified that Audet should have sent a blank form for Dr. Holloway to fill out himself. Dr. Elkin's testified that he considered the restrictions indicated on the form were reasonable.

Arneson hired Audet to perform a vocational assessment. Prior to issuing his opinion, Audet reviewed Arneson's file and related exhibits. He also reviewed the depositions of Dr. Holloway, Dr. Elkins, and Dr. Brody as well as the reports of Jim Carroll. He reviewed Arneson's medical records as well. Audet spoke with Arneson on three occasions. He then assessed Arneson's Residual Functional Capacity based on the Physical Capacities Form he discussed with Arneson and was then approved by Dr. Holloway. Audet was unable to find jobs that Arneson could perform with his restrictions, education, and work history. However, he opined that given Arneson's age and restrictions it was futile for him to seek a job and retraining was not feasible. He concluded that Arneson is permanently and totally disabled and not capable of earning

his workers' compensation rate.

The Department concludes that Arneson is obviously unemployable. The Court has guided the Department to consider a claimant's situation in the aggregate. *Billman* at ¶ 41. Arneson has physical limitations that restrict what sorts of jobs he can do involving his hands, and he must take regular, unpredictable breaks of between 10 and 30 minutes. In *Billman*, the Court held, "outside of physically accommodating Billman, an employer would likely have to spend time and resources to train him—a person set to retire in a few years." *Id* at ¶ 39. The same can be said for Arneson who is within the age of retirement and would require training in a new position. Based on these facts, the Department finds that Audet's conclusion that Arneson is permanently and totally disabled is accurate.

However, Department is unable to conclude that Arneson was permanently and totally disabled prior to February 3, 2020, when Dr. Holloway signed the Physical Capacities Form establishing his restrictions. Arneson willingly retired from his position with Employer on June 1, 2019, without any medical restrictions in place and without asking for any accommodations. He had been able to perform the job satisfactorily before retiring from the position. Arneson's coworker, Kurt Hall (Hall) testified that Employer would have been willing to address accommodations he might have needed. During Prado's testimony, she stated that Arneson was a good, reliable worker whose knowledge she considered a valuable asset. Prior to his retirement, he had been delegating more to other staff which was something he had been encouraged to do more often. She stated that he was eligible for rehire. Arneson has not proven that he was permanently and totally disabled between the time he chose to leave his

employment and when Dr. Holloway signed off on the restrictions. Therefore, any benefits he is entitled to regarding past permanent and total disability benefits will not include the time between June 1, 2019, and February 3, 2020. Arneson's past disability benefits shall be calculated from February 3, 2020, at his compensation rate of $575.16 per week. Additionally, as Arneson has met his prima facie showing of permanent and total disability it is unnecessary for the Department to consider the availability of suitable employment in his community.

Conclusion:

Arneson has proven by a preponderance of the evidence that the electrical shock he experienced on July 18, 2018, is a major contributing cause of his condition.

Arneson has proven he is permanently and totally disabled and made a prima facie showing of entitlement to benefits under the odd-lot category.

Arneson is entitled to past disability benefits from February 3, 2020, at his compensation rate of $575.16 per week.

Arneson is entitled to ongoing medical and disability benefits unless, and until, Employer and Insurer can show there was a change of condition pursuant to SDCL 62-7-33.

Arneson shall submit Findings of Fact and Conclusions of Law and an Order consistent with this Decision within twenty (20) days from the date of receipt of this Decision. Employer and Insurer shall have an additional twenty (20) days from the date of receipt of Arneson's Proposed Findings and Conclusions to submit objections thereto and/or to submit their own proposed Findings of Fact and Conclusions of Law. The

parties may stipulate to a waiver of Findings of Fact and Conclusions of Law and if they do so, Arneson shall submit such Stipulation along with an Order consistent with this Decision.

Dated this day of March 21, 2023.

SOUTH DAKOTA DEPARTMENT OF
LABOR & REGULATION

Michelle Faw

Michelle M. Faw
Administrative Law Judge

SOUTH DAKOTA DEPARTMENT OF LABOR
DIVISION OF LABOR AND MANAGEMENT
WORKERS' COMPENSATION

MICHAEL ARNESON,	)	**HF No. 1, 2019/20**
	)	
Claimant,	)	
	)	
vs.	)	
	)	
GR MANAGEMENT, LLC, d/b/a MINERAL PALACE CASINO,	)	**ORDER**
	)	
Employer, and	)	
	)	
RISK ADMINISTRATION SERVICES, INC.,	)	
	)	
Insurer.	)	

The above-entitled matter came on for hearing before the Honorable Michelle Faw, South Dakota Department of Labor and Regulation, Division of Labor & Management, on September 14, 2022. Claimant Michael Arneson (Arneson) was represented by Brad J. Lee, Conor Casey, and Michael S. Beardsley of Beardsley, Jensen & Lee. Employer and Self-insurer were represented by Charles A. Larson of Boyce Law Firm. The Department having heard the evidence, reviewed the briefs, and having issued its Decision on March 21, 2023, having entered its Findings of Fact and Conclusions of Law, and for good cause appearing, it is hereby:

ORDERED AND ADJUDGED that Arneson has proven by a preponderance of the evidence that the electrical shock he experienced on July 18, 2018, is a major contributing cause of his condition;

It is further ORDERED AND ADJUDGED, that Arneson has proven he is permanently and totally disabled and made a prima facie showing of entitlement to benefits under the odd-lot category;

It is further ORDERED AND ADJUDGED, that Arneson is entitled to past disability benefits from February 3, 2020, at his compensation rate of $575.16 per week;

It is further ORDERED AND ADJUDGED, Arneson is entitled to ongoing medical and disability benefits unless, and until, Employer and Insurer can show there was a change of condition pursuant to SDCL 62-7-33.

Dated this 28 day of April 2023.

BY THE DEPARTMENT:

Michelle Faw

Michelle M. Faw
Administrative Law Judge

SOUTH DAKOTA DEPARTMENT OF LABOR
DIVISION OF LABOR AND MANAGEMENT
WORKERS' COMPENSATION

MICHAEL ARNESON,	)	**HF No. 1, 2019/20**
	)	
Claimant,	)	
	)	
vs.	)	
	)	
GR MANAGEMENT, LLC, d/b/a MINERAL PALACE CASINO,	)	**FINDINGS OF FACT AND CONCLUSIONS OF LAW**
	)	
Employer, and	)	
	)	
RISK ADMINISTRATION SERVICES, INC.,	)	
	)	
Insurer.	)	

The above-entitled matter came on for hearing before the Honorable Michelle Faw, South Dakota Department of Labor and Regulation, Division of Labor & Management, on September 14, 2022. Claimant Michael Arneson ("Claimant") was represented by Brad J. Lee, Conor Casey, and Michael S. Beardsley of Beardsley, Jensen & Lee. Employer and Self-insurer were represented by Charles A. Larson of Boyce Law Firm.

The Department heard live testimony from Michael Arneson, Brian Ledbetter, Connie Teale, Diana Prado, and Kurt Hall, who were all present. Those testifying by Zoom were Tom Audet, Jim Carroll, and Dr. Bruce Elkins. The matter was then extensively briefed by the parties. The Department having heard the evidence, reviewed the briefs, and good cause showing, and having issued its Decision on March 21, 2023, enters the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Michael Arneson (Arneson) was born on August 24, 1955.

2. In 1972, Arneson left school to join the United States Navy.

3. He received his GED.

4. 45 days after enlisting in the Navy, he was honorably discharged due to an issue with his eyesight.

5. He then attended several six-month courses wherein he achieved training in electrical systems, plumbing, machine operation, and swimming pool systems.

6. He received OSHA training and received multiple professional certifications.

7. Arneson also earned an Associate degree in finance.

8. Arneson applies his education to various occupations.

- From 1974 to 1989, Arneson worked at Atlas Mill as a machine operator and part technician.
- From 1989 to 1991, Arneson worked for Dusheck Trucking as an over-the-road truck driver.
- From 1991 to 2006, Arneson started his own business called Arnie's All Season Repair and Arneson Engine Rebuilders where he rebuilt engines and performed auto repair.
- From 2006 to 2014, Arneson worked for Harley Davidson as head of maintenance and cleaning of machinery.
- From 2014 to 2015, Arneson worked for Rivers Hotel Group as the maintenance manager.

9. On September 15, 2015, Arneson began working as the maintenance manager for GR Management, LLC, d/b/a Mineral Palace Casino (Employer) which was at all times pertinent to this matter insured for workers' compensation purposes by Risk Administration Services (jointly, Employer and Insurer).

10. His duties included overseeing maintenance personnel, cleaners, and valet; painting, tiling, carpentry, snow removal, lawn care, and miscellaneous cleaning;

servicing exhaust units, A/C units, and kitchen equipment; and also monitoring the plumbing and electrical units.

11. On July 17, 2018, an electrical storm caused a power outage at the Mineral Palace.

12. Arneson checked out the facility and its equipment.

13. He then shut off the equipment with the plan to return in the morning to check everything again.

14. The next morning, on July 18, 2018, Arneson arrived at the Mineral Palace at 6:30 a.m. to assess the damage from the electrical storm.

15. He checked the exhaust fan and then went on the roof to turn off the shunt which cuts power to the fan.

16. After checking there were no shorts in the wires, he turned the breaker on and confirmed all three lines had power.

17. He then went back on the roof to turn the shunt back on.

18. When Arneson touched the shunt, it shorted which caused electrocution.

19. Initially, he did not feel anything but shortly after his hand started to tingle.

20. He removed his gloves and observed that his fingers were burned on his right hand.

21. Arneson went home, showered, washed his right hand with soap and water, and then applied an antibiotic ointment to his hand before going to the Lead-Deadwood Emergency Department.

22. At the Emergency Department, he reported the burns on his hand as well as a hole in his left foot which represented where the electricity exited his body.

23. He also reported a tingly feeling in the fingertips of his right hand.

24. His doctor noted that his hand complaints were likely to be related to carpal tunnel syndrome.

25. The medical staff performed an electrocardiogram of Arneson's heart which was normal.

26. His heart rate was regular with a normal sinus rhythm.

27. He was sent home with information about electrical injury and burn care, and it was recommended that he change his dressings as directed, apply antibiotic ointment, and to take over-the-counter pain relievers.

28. On July 20, 2018, Arneson went to Black Hills Orthopedic reporting that he was riding his motorcycle and his thumb, index, and middle fingers went numb.

29. Dr. Zachary Jager examined Arneson and noted the burns on his fingers were improving.

30. He also discussed with Arneson that the numbness in his middle fingers may be associated with carpal tunnel syndrome.

31. Dr. Jager noted that Arneson did not display any cardiovascular symptoms.

32. Arneson was encouraged to call if his symptoms were not improving, but there was no record he contacted Dr. Jager after that day.

33. Arneson completed and signed an employee injury report on July 24, 2018.

34. The report did not include any references to heart problems after the electrocution.

35. Arneson continued to work at the Mineral Palace.

36. Over the next ten or so days after the electrocution incident, he began to feel heart palpitations.

37. He was not concerned about the palpitations until July 30, 2018, when he and his co-worker were moving slot machines at the Mineral Palace.

38. Arneson experienced an episode of supraventricular tachycardia (SVT).

39. Arneson immediately went to the Lead-Deadwood Emergency Department.

40. His heart rate was 195 beats per minute, blood pressure was only 76/48, and he was experiencing chest pain, dizziness, and heart palpitations.

41. Arneson was then sent to the intensive care unit (ICU) where he was treated for the next two and a half days.

42. Arneson was treated by Dr. Mark Ptacek who noted Arneson had no heart issues until July 30, 2018.

43. Dr. Ptacek noted that the context provided by Arneson for his condition was caffeine.

44. On July 31, 2018, Arneson was treated by his doctor, Dr. James Holloway, who diagnosed him as suffering from atrial fibrillation (AFib) and hyperthyroidism.

45. Dr. Holloway wrote to Arneson on August 5, 2018, informing him that the echocardiogram showed Arneson's heart findings were normal, and he was encouraged that Arneson would be able to maintain a normal heart rhythm once his hyperthyroidism was under control.

46. After being discharged from the hospital, Arneson continued to experience heart palpitations which caused him to feel fatigued.

47. At first, the AFib occurred approximately four times a day which caused Arneson to require rest from a few minutes to half an hour.

48. Arneson's doctors attempted to treat the AFib and episodes of SVT with medications and by destroying his thyroid without success.

49. Arneson had not had any episodes of heart palpitations, thyroid issues, or heart issues prior to the electrocution incident on July 18, 2018.

50. There were no medical records indicating heart complaints prior to July 30, 2018.

51. On August 22, 2018, Dr. Holloway confirmed that Arneson had hyperthyroidism and Graves' Disease.

52. A week later, he started Arneson on medication to treat hyperthyroidism.

53. Arneson continued to report episodes of AFib and so his medication was adjusted on September 26, 2018.

54. By December 10, 2018, Dr. Holloway noted that Arneson's thyroid levels were normal, and there had been no recent episodes of AFib.

55. Arneson also had increased energy levels and reported no unusual tiredness or fatigue.

56. He was advised to contact the office if he noticed palpitations or rapid heart rate which were signs of too little hyperthyroid medication.

57. On January 18, 2019, Arneson was provided a heart monitor which monitored his heart rhythm for a continuous 48-hour period.

58. The results were normal, and he reported no symptoms during that time.

59. He did not report having issues with his heart again until March 7, 2019, when he reported an episode of palpitation that had occurred a few days prior.

60. He stated that he had missed his medication two days prior to the episode.

61. He was advised not to miss doses of his medication.

62. On June 1, 2019, Arneson left his job at Mineral Palace because of the AFib, fatigue, and right-hand numbness led him to conclude he could no longer perform his job duties.

63. On April 9, 2019, Dr. Holloway noted the results of a Ct Angiogram performed on Arneson revealed a diffuse nonobstructive 20-30% plague throughout all three of his coronary arteries.

64. On September 17, 2020, Arneson visited Dr. Holloway complaining that he was tired.

65. He stopped taking his medication on August 16, 2020, because they were causing a rash.

66. His hyperthyroidism was no longer regulated.

67. On October 8, 2020, Dr. Holloway noted that Arneson reported his heartbeat would "take off" now and then but did not race.

68. He was back on hyperthyroid medicine.

69. His heart sometimes skipped beats later in the evening, but he did not experience a rapid heart rate.

70. On April 21, 2021, Arneson was treated with radioactive iodine therapy which caused him to develop hypothyroidism instead of hyperthyroidism.

71. On February 24, 2022, Arneson was seen by Dr. John Palmer

who noted that he had suffered an electric shock and subsequently developed significant heart arrhythmias.

72. Dr. Palmer noted that Arneson continued to have frequent heart complaints.

73. Employer and Insurer denied Arneson's workers' compensation claim on May 10, 2019. Arneson submitted his Petition for Hearing to the Department of Labor & Regulation on June 28, 2019.

74. Other facts will be determined as necessary.

CONCLUSIONS OF LAW

1. The Department has jurisdiction over the parties and the subject matter of this litigation.

2. To the extent that any Findings of Fact herein are improperly designated as such, then they should be considered Conclusions of Law.

3. Likewise, to the extent that any Conclusion of Law contained herein are improperly designated as such, then they should be considered as Findings of Fact.

4. The issues presented at the hearing were:

- Nature and extent of injury;
- Major contributing cause; and
- Permanent total disability

Nature and Extent of Injury and Major Contributing Cause:

5. To prevail in this matter, Arneson must first prove that his work-related injury is a major contributing cause of his condition.

6. SDCL § 62-1-1(7) provides, in pertinent part:

> "Injury" or "personal injury," only injury arising out of and in the course of the employment, and does not include a disease in any form except as it results from

> the injury. An injury is compensable only if it is established by medical evidence, subject to the following conditions:
> (a) No injury is compensable unless the employment or employment related activities are a major contributing cause of the condition complained of; or
> (b) If the injury combines with a preexisting disease or condition to cause or prolong disability, impairment, or need for treatment, the condition complained of is compensable if the employment or employment related injury is and remains a major contributing cause of the disability, impairment, or need for treatment;

7. Arneson is "not required to prove his employment was the proximate, direct, or sole cause of his injury." *Smith v. Stan Houston Equip. Co.*, 2013 S.D. 65, ¶ 16, 836 N.W.2d 647, 652.

8. He must prove "that employment or employment-related activities [are] a major contributing cause of the condition of which [he] complained, or, in cases of preexisting disease or condition, that employment or employment-related injury is and remains a major contributing cause of the disability, impairment, or need for treatment." *Norton v. Deuel School Dist. No. 19-4*, 674 N.W.2d 518, 521 (S.D. 2004).

9. "The fact that an employee may have suffered a work-related injury does not automatically establish entitlement to benefits for his current claimed condition." *McQuay v. Fischer Furniture*, 2011 S.D. 91, ¶ 11 808 N.W.2d 107, 111 (citations omitted).

10. The standard of proof for causation in a worker's compensation claim is a preponderance of the evidence. *Armstrong v. Longview Farms, LLP,* 2020 S.D. 1, ¶ 21, 938 N.W.2d 425, 430.

11. "The testimony of professionals is crucial in establishing this causal relationship because the field is one in which laymen ordinarily are unqualified to express an opinion." *Day v. John Morrell & Co.*, 490 N.W.2d 720, 724 (S.D. 1992).

12. Arneson has offered the opinions of Dr. Holloway.

13. Employer and Insurer have offered the opinions of Dr. Brody and Dr. Elkins.

14. The medical experts opined on Arneson's AFib, fatigue, and hand issues.

15. The Department will address the issue of the AFib first.

Dr. Holloway

16. Dr. Holloway graduated from Indiana University Medical School in 1979.

17. He performed an internal medicine residency for the next three years then did a two-year internal medicine fellowship at Johns Hopkins.

18. Dr. Holloway has been a practicing internist at the Deadwood Regional Medical Clinic from 1992 to the present.

19. Dr. Holloway has been Arneson's primary treating doctor following his electrocution.

20. Prior to his deposition on September 18, 2020, he reviewed all of Arneson's medical records from Regional Health, Black Hills Orthopedic, and Spine Center, as well as the medical records summary identified as Hearing Exhibit 2.

21. At his deposition, Dr. Holloway was asked if he had conducted any independent research related to electrical injuries and AFib.

22. He answered that he had reviewed an online resource called UpToDate Textbooks on Cardiology.

23. He specifically mentioned that he researched electrical injury and cardiac arrhythmias as well as the relationship between thyroid conditions and cardiac arrhythmias including AFib.

24. Dr. Holloway opined that the electrical work injury suffered by Arneson was a major contributing cause of his AFib.

25. At his deposition, Dr. Holloway also reviewed a form regarding electric shock injury that Arneson was provided when he was discharged from the Lead-Deadwood Emergency Department.

26. The form specifically mentioned that a strong electric shock could harm the heart. It specifically listed the following symptoms: tingling and numbness, very bad pain; skin burns, chest pain; and very fast irregular heartbeat.

27. Dr. Holloway discussed how the most common injuries that manifest following the passage of an electrical current through the body, are related to the heart because the heart is an electrical organ as well as a muscular organ.

28. He testified that most serious electrical shock injuries occur with a voltage over 600 volts.

29. He also testified that any time there is a passage of electrical current through the body it can cause damage to the cells it passes through.

30. He stated that cellular damage caused by the electrical current can often cause long-term lasting effects.

31. Dr. Holloway provided that he did not know the type of current Arneson was exposed to or the duration of that exposure.

32. Dr. Holloway found it significant that Arneson presented with the AFib a short time after having had the electrical injury.

33. He stated it was very common for people to have rhythm disturbances after an electrical injury.

34. Dr. Holloway testified that AFib may cause issues with dizziness, lightheadedness, and inability to stand.

35. People can get very dizzy or even collapse with AFib.

36. Dr. Holloway was also asked to discuss the relationship between the work injury and Arneson's thyroid condition.

37. He stated that the thyroid issue was not related to the electrical injury.

38. He also stated that hyperthyroidism is a predisposing factor for the development of AFib, but only about 5 to 15 percent of patients with hyperthyroidism develop AFib.

39. Further, he testified that thyroid issues often present quickly because a person reaches a certain threshold where symptoms occur.

40. He further testified that he was unaware of any data that would give a specific time for AFib to occur following a shock.

41. He stated that he would not consider AFib occurring a year later to be related, but weeks to a few months afterward, he would probably attribute the AFib at least in a large part to the shock.

42. He opined that it was more likely than not that Arneson would not have developed AFib without the electric shock, because the majority of people with hyperthyroidism do not develop AFib.

43. Dr. Holloway testified that the fact that Arneson smokes a pack of cigarettes a day probably increased his risk of AFib.

44. Dr. Holloway has not reviewed Arneson's recent medical records since his deposition, and he has not reviewed Dr. Elkins' or Dr. Brody's opinions.

45. Employer and Insurer contend that Dr. Holloway's understanding of the mechanism of injury is flawed because he has mistakenly assumed that Arneson experienced a high-voltage electrical shock.

46. However, Dr. Holloway testified that he did not know the specific voltage or duration of the shock, but he presumed the type of current Arneson was exposed to be a standard outlet with AC current such as would be in a home.

47. Thus, it is not clear from his testimony that he assumed it was high voltage.

Dr. Brody

48. Dr. Brody attended medical school at the University of Minnesota graduating in 1983.

49. He then attended an internal medicine internship at the New England Deaconess Hospital in Boston, Massachusetts for one year.

50. He became a resident of internal medicine at Hennepin County Medical Center at the University of Minnesota for two years and then attended a fellowship in cardiovascular medicine at the West Roxbury VA in Boston for two years.

51. He returned to Hennepin County Medical Center for a cardiology fellowship.

52. Dr. Brody then practiced cardiology in St. Paul, Minnesota.

53. He is also board certified in internal medicine and cardiology.

54. Dr. Brody performed a review of Arneson's medical records on March 20, 2020.

55. He was also provided supplemental records and was deposed on January 6, 2021.

56. At deposition, Dr. Brody answered no to questions regarding whether he considered himself an expert in treating and testifying about thyroid problems or individuals that had hyperthyroidism that had been subject to electrical shock.

57. Dr. Brody testified at deposition that he was very familiar with AFib and that of the 100 patients he had seen in the last two months, 32 had AFib.

58. He also stated he was familiar with the issues that can occur with the heart after an electrical shock.

59. Regarding the July 18, 2018, work-related injury, Dr. Brody addressed the records from the emergency department which did not note abnormal findings or indicate an injury to Arneson's heart.

60. Arneson's EKG was normal which indicated to Dr. Brody that there was no evidence the electrical shock caused structural damage to his heart.

61. Dr. Brody concluded that the electrical shock Arneson experienced was not a major contributing cause of the AFib.

62. He based his opinion on two factors: (1) AFib generally occurs on the same day as the electrical injury; and (2) there are essentially no reports of an association of AFib occurring 12 days after an electrical injury in his research or in his experience as a treating physician.

63. Dr. Brody looked at the results of Arneson's EKG and found that it was normal.

64. He also reviewed Arneson's medical records and found no indication of cardiac symptoms prior to July 30, 2018.

65. He stated there was no evidence that the electrical shock caused any structural heart disease that triggered AFib.

66. Dr. Brody testified that it may be possible for an electrical injury to cause AFib, but he has seen less than five cases of it happening in his forty years of practice.

67. He also stated that based on his research AFib after the electrical shock was very rare.

68. One study he reviewed stated a .6% chance of getting AFib from an electrical shock.

69. Although, he did find an article concerning a patient who suffered a low-voltage shock and then developed AFib six weeks after the event.

70. Dr. Brody was also asked about hyperthyroidism and AFib.

71. He considered the 10 to 15 percent chance of AFib with hyperthyroidism to be a fairly common thing in medicine.

72. He testified that it was most likely that Arneson had hyperthyroidism prior to the July 18 incident, and he did not have symptoms or AFib prior to the electrocution.

73. He did not know what caused Arneson's hyperthyroidism to become symptomatic and caused him to go into AFib.

Dr. Elkins

74. Dr. Elkins graduated medical school in 1993 at the University of Wisconsin.

75. He then performed a preventative medicine residence at the Loma Linda University Medical Center and was selected as chief resident.

76. He is board certified in occupational medicine and was board certified in preventative medicine.

77. Dr. Elkins practiced occupational medicine in Bettendorf, Iowa until he became Medical Director for Occupational medicine at Avera in Sioux Falls, SD in 2004.

78. He practiced at Avera for 12 years.

79. He currently practices at the Sioux Falls VA hospital and Elkins Medical Services.

80. Dr. Elkins testified live at the hearing.

81. Dr. Elkins performed a review of all Arneson's available medical records.

82. He also reviewed the depositions of both Dr. Holloway and Dr. Brody.

83. To aid him in forming his opinion, he also researched Graves' Disease, hyperthyroidism, electrical shock injuries, and the incidence of arrhythmias caused by both hyperthyroidism and electrical injuries.

84. He produced three medical record review reports, and all his opinions were provided within a reasonable degree of medical certainty or probability.

85. He testified that the shock Arneson experienced was DC current, and DC current is less medically destructive than AC current.

86. He opined that had Arneson sustained a heart injury from the electrical shock, he would have had symptoms of damage within the first 12-24 hours following the incident, but he did not show signs of damage or arrhythmia until twelve days later.

87. He further agreed upon questioning that it was common for people who have developed sustained AFib to have brief "transient palpitations" that they ignore, but then suffer a full-blown AFib episode. (HT 273:20-274:71[1]).

88. Dr. Elkins testified that suffering from Graves' Disease, along with his age and that he is a white male made Arneson more likely to develop AFib.

89. He added that Arneson's history as a smoker increased his risk.

[1] References to the hearing transcript will be indicated with "HT".

90. He further opined that most electrical shock injuries causing serious damage to the body require greater than 600 volts and the shock Arneson received 440 volts.

91. In his opinion, the electrocution was not a major contributing cause of Arneson's condition, need for treatment, or need for work restrictions.

92. He also stated that it was possible that somebody could experience arrhythmia days after electrocution.

93. He also agreed that an article he referenced to prepare his opinion showed that low-voltage electrocution could cause cardiac injuries.

94. He further conceded that prior to the electrocution, Arneson's hyperthyroidism and Graves' disease were asymptomatic.

95. He also testified that Arneson's condition was worsening, and the reason was unknown.

96. At hearing, Dr. Elkins was asked a series of questions about his expertise.

96. He answered that he did not consider himself an expert in treating patients with AFib, Graves' Disease, thyroid problems, or cardiac problems.

97. He was also asked if he had special training in these areas or whether he treated thyroid problems on a continuing basis. His answer indicated that he did not.

98. Arneson contends that due to his lack of expertise in these specific areas, Dr. Elkins is not qualified to testify whether Arneson's injuries were caused by the electrocution.

Analysis

99. The Department will first address whether the experts' opinions are supported by the necessary foundation.

100. "The value of the opinion of an expert witness is no better than the facts upon which they are based. It cannot rise above its foundation and proves nothing if its factual basis is not true." *Schneider v. S. Dakota Dep't of Transp.*, 2001 S.D. 70, ¶ 16, 628 N.W.2d 725, 730 (citations omitted).

101. Dr. Holloway is Arneson's treating physician and he reviewed medical records prior to his deposition.

102. He has not reviewed records since his deposition or provided an updated opinion.

103. The South Dakota Supreme Court (Court) has clarified that experts are not "required to consider all of a claimant's medical records to establish an adequate foundation for their opinions." *News Am. Mktg. v. Schoon*, 2022 S.D. 79, ¶ 38, 984 N.W.2d 127, 138–39.

104. The Department concludes that Dr. Holloway's opinion is based on adequate foundation.

105. Dr. Brody and Dr. Elkins are not treating physicians, but they have reviewed Arneson's medical records and reports.

106. The Court has held that a non-treating physician's opinion can be more persuasive than the opinion of a treating physician on causation issues. *Helms v. Lynn's Inc.*, 1996 S.D. 8, 542 N.W. 2d 764.

107. Both doctors have sufficient foundation for their opinions.

108. The Court has held that causation must be proven to "a reasonable degree of medical probability, not just possibility." *Jewett v. Real Tuff, Inc.*, 2011 S.D. 33, ¶ 23, 800 N.W. 2d 345, 350.

109. The data provided by the doctors shows that developing AFib whether due to electrical shock or hyperthyroidism is uncommon.

110. Arneson developed an uncommon condition and the question before the department is whether it is probable that the electrical shock he experienced on July 18, 2018, was a major contributing cause of that condition.

111. Having reviewed the record and the doctors' opinions, the Department finds that it is probable that the electric shock experienced by Arneson is a major contributing cause of his development of AFib and his current condition.

112. Dr. Brody and Dr. Elkins opined that it was very rare for AFib to be caused by an electrical shock and had the injury caused the AFib, the symptoms would have appeared soon after the shock.

113. However, both doctors testified that there have been cases of AFib after an electrical shock and cases where an individual's shock related AFib developed later.

114. Regarding the development of Arneson's palpitations, Employer and Insurer point to an employee injury report completed and signed by Arneson on July 24, 2018.

115. The report required Arneson to note all injuries he received from the accident on July 18, 2018.

116. He did not include any references to heart concerns.

117. Arneson testified at the hearing that he was experiencing minor palpitations for the first couple of days following the shock but considered them to be a "fluke." (HT 29:22).

118. Dr. Holloway opined that it was not uncommon for people to disregard those kinds of brief palpitations.

119. He also testified that he had witnessed Arneson minimizing symptoms and failing to report conditions or problems such as when he developed a rash due to a medication.

120. Dr. Elkins also confirmed that it was common for individuals to develop transient palpitations that they ignore.

121. The Department finds Arneson's testimony to be credible and believes that he did experience palpitations that he disregarded until they became serious enough that he went to the emergency department on July 30, 2018.

122. While Arneson has multiple conditions, traits, and habits that increase the likelihood he would develop AFib such as Graves' disease, his smoking habit, and that he is a white male, the Department finds that the electrical shock he experienced was a major contributing cause.

123. The Court has held that a work incident does not need to be "the" major contributing cause but need only be "a" major contributing cause. *Hughes v. Dakota Mill Grain, Inc. and Hartford Insurance*, 2021 S.D. 31, ¶ 22, 959 N.W.2d 903.

124. Dr. Holloway testified that the most common injuries following an electrical injury are to the heart and such injuries can cause long-term effects.

125. Additionally, he considered the fact Arneson developed heart palpitations within a short time period significant.

126. The Department is persuaded by Dr. Holloway's analysis and his conclusion that it is more likely than not that Arneson developed AFib as a result of the electric shock.

127. Thus, the Department is persuaded that the electrical injury Arneson sustained is a major contributing cause of his current condition.

128. The Department will next address the issue of Arneson's hand injury.

129. Dr. Holloway opined that the numbness was not the same as it was when it first started, but it was still present.

130. He further testified that Arneson had recovered some function, and his numbness is present but not as bad as it had been when it first started.

131. Dr. Holloway mentioned that Arneson has difficulty with fine motor skills, and he cannot feel things that he is picking up or touching with his dominant hand.

132. This can result in breaking things in the hand.

133. He further stated that Arneson is more likely to drop things due to his lack of feeling.

134. He had observed that Arneson grabs things differently than most people.

135. Specifically, he will not use the tip of his thumb to grab things because he cannot feel it so he uses the thumb joint.

136. Dr. Holloway testified that this could result in future arthritic problems.

137. Arneson is also unable to feel hot and cold well.

138. Dr. Holloway opined that the reduced sense of pain in his hand could result in injury because he would not recognize pain immediately and could sustain a serious injury due to the lack of sensation.

139. He testified that if a damaged nerve is going to recover, it usually happens within the first six to twelve months, but it can take up to a couple of years.

140. Arneson has experienced partial recovery, but he still has limitations.

141. Dr. Brody was asked whether he agreed that the work injury was the cause of the numbness Arneson was experiencing after the electrical shock, and he agreed that it was.

142. Dr. Elkins opined that the electrocution was not a major contributing cause of Arneson's hand issue with the possible exception of some fingertip numbness.

143. He stated that Arneson's hand symptoms are inconsistent with electrical injury and his current symptoms are different than what he presented with at the time of the incident.

144. He also testified that Arneson was able to work and ride his motorcycle cross-country following the incident, but he now complains of incoordination which was not present in the days, weeks, and months after the injury.

145. Dr. Elkins opined that Arneson's worsening symptoms cannot be explained by an electrical injury.

146. Dr. Elkins mentioned the possibility of carpal tunnel syndrome due to the distribution of the numbness in Arneson's hand.

147. Arneson has not been diagnosed with carpal tunnel syndrome.

148. He also opined that Arneson did not complain of incoordination initially and that when symptoms change over time the diagnosis should be reconsidered.

149. The Department is persuaded by Dr. Holloway's testimony that the electrical shock injury is a major contributing cause of Arneson's ongoing issues with numbness and sensation in his right hand.

150. It appears that the electrical shock caused nerve damage that has only partially healed and as of the time of the hearing, he was still experiencing significant issues with his hand.

151. Additionally, the medical record shows that Arneson has consistently complained of finger numbness and paresthesia since the injury.

152. The electrical injury is a major contributing cause of Arneson's right-hand issues.

Permanent and Total Disability:

153. To make a prima facie showing that he is entitled to odd-lot benefits, Arneson must prove either that due to his physical condition, coupled with his education, training, and age, it is obvious that he is obviously unemployable, or 2) that he is in the kind of continuous severe and debilitating pain which he claims. *Eite v. Rapid City Area Sch. Dist. 51-4*, 2007 SD 95, ¶21, 739 N.W.2d 264, 270-71. (citations omitted).

154. SDCL 62-4-53 provides:

> An employee is permanently totally disabled if the employee's physical condition, in combination with the employee's age, training, and experience and the type of work available in the employee's community, cause the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income.
>
> An employee has the burden of proof to make a prima facie showing of permanent total disability. The burden then shifts to the employer to show that some form of suitable work is regularly and continuously available to the employee in the community. The employer may meet this burden by showing that a position is available which is not sporadic employment resulting in an insubstantial income as defined in subdivision 62-4-52(2). An employee shall introduce evidence of a reasonable, good faith work search effort unless the medical or vocational findings show such efforts would be futile. The effort to seek employment is not reasonable if the employee places undue limitations on the kind of work the employee will accept or purposefully leaves the labor market. An employee shall introduce expert opinion evidence that the employee is unable to benefit from vocational rehabilitation or that the same is not feasible.

155. SDCL 62-4-52 defines "sporadic employment resulting in an insubstantial income," as:

> employment that does not offer an employee the opportunity to work either full-time or part-time and pay wages equivalent to, or greater than, the workers' compensation benefit rate applicable to the employee at the time of the employee's injury. Commission or piece-work pay may or may not be considered sporadic employment depending upon the facts of the individual situation. If a bona fide position is available that has essential functions that the injured

> employee can perform, with or without reasonable accommodations, and offers the employee the opportunity to work either full-time or part-time and pays wages equivalent to, or greater than, the workers' compensation benefit rate applicable to the employee at the time of the employee's injury the employment is not sporadic. The department shall retain jurisdiction over disputes arising under this provision to ensure that any such position is suitable when compared to the employee's former job and that such employment is regularly and continuously available to the employee.

156. The Court has provided two ways a claimant can make a prima facie showing of entitlement to benefits under the odd-lot category. "(1) claimant is obviously unemployable due to his or her physical condition, coupled with his or her age, training, and experience, or (2) unavailability of suitable employment by showing that he or she has made reasonable efforts to find work and was unsuccessful." *Billman v. Clarke Mach., Inc.*, 2021 S.D. 18, ¶ 25, 956 N.W.2d 812, 820.

Age, Training, and Experience

157. Arneson asserts that he is permanently and totally disabled, obviously unemployable and that his physical condition, education, training, and age place him in the odd-lot total disability category.

158. He was born in 1955 and as of the time of the hearing was 67 years old.

159. He received his GED, and his work history has mainly been hands-on maintenance work, over-the-road trucking, and mechanical repair.

160. He also has an Associate of Arts degree in finance but none of his past jobs have applied the degree.

161. Employer and Insurer contend that Arneson is not obviously unemployable and his skills as a supervisor are extremely marketable, uncommon, and easily transferrable to different employment opportunities.

162. Additionally, he has an excellent work history and a degree in finance that makes him marketable for sedentary-type work.

163. Arneson also has a number of licenses including electrical, plumbing, and federal MACS.

164. Arneson continued to work full-time for Employer for over ten months after the accident at which time he voluntarily retired.

165. At the time of his retirement, he had no medical restrictions and he had not requested an accommodation.

166. Arneson testified that he had employees that could help him with certain duties such as heavy work with which he struggled.

167. He was not reprimanded at work for delegating too much to employees and was, in fact, encouraged to do so more often.

168. Employer and Insurer assert these facts indicate that he would have been able to continue in his position as a supervisor.

169. His manager, Diana Prado (Prado), testified that prior to his retirement, Arneson's performance was between good and exceptional for 2018.

170. Since retiring, Arneson has performed mechanical work on vehicles belonging to his wife or friends.

171. He testified he is able to work on projects using his right hand including working on vehicles and motorcycles.

172. He was also able to help his friends move.

173. At one point, he was able to ride his motorcycle on a trip lasting 15 hours.

Physical Condition

174. Arneson has offered the expert vocational opinion of Tom Audet.

175. Audet spoke with Arneson regarding his limitations and produced a Physical Capacities Form.

176. Audet then asked Dr. Holloway to review the form and sign it if he agreed.

177. The Physical Capacities Form, as signed by Dr. Holloway, reflects Arneson's abilities regarding his right hand as occasional handling, feeling, firm grasping, and pushing or pulling.

178. It further indicates that Arneson can never perform fine finger manipulation or light grasping and that Arneson is able to occasionally bend, squat, kneel, or climb.

179. Arneson's lack of sensation results in an inability to detect heat and cold.

180. Due to the AFib and his medications, Arneson is at risk while using dangerous machinery.

181. Additionally, Dr. Holloway testified that Arneson could work an eight-hour day if it was within his other restrictions.

182. He also stated if Arneson experiences AFib he has to stop and rest for between five and twenty minutes and it typically occurs three to four times per week.

183. He further testified that on the Physical Capacities Form, the noted limitations regarding standing/walking and sitting were referring more to individuals in general and not Arneson specifically.

184. Additionally, the medical records show multiple instances of Arneson reporting experiencing fatigue.

185. Employer and Insurer provided the expert vocational opinion of Jim Carrol who asserted that it was inappropriate for Audet to fill out the form and have Dr. Holloway sign it.

186. He testified that Audet should have sent a blank form for Dr. Holloway to fill out himself.

187. Dr. Elkin's testified that he considered the restrictions indicated on the form were reasonable.

188. Arneson hired Audet to perform a vocational assessment.

189. Prior to issuing his opinion, Audet reviewed Arneson's file and related exhibits.

190. He also reviewed the depositions of Dr. Holloway, Dr. Elkins, and Dr. Brody as well as the reports of Jim Carroll.

191. He reviewed Arneson's medical records as well.

192. Audet spoke with Arneson on three occasions.

193. He then assessed Arneson's Residual Functional Capacity based on the Physical Capacities Form he discussed with Arneson and was then approved by Dr. Holloway.

194. Audet was unable to find jobs that Arneson could perform with his restrictions, education, and work history.

195. However, he opined that given Arneson's age and restrictions it was futile for him to seek a job and retraining was not feasible.

196. He concluded that Arneson is permanently and totally disabled and not capable of earning his workers' compensation rate.

197. The Department concludes that Arneson is obviously unemployable.

198. The Court has guided the Department to consider a claimant's situation in the aggregate. *Billman* at ¶ 41.

199. Arneson has physical limitations that restrict what sorts of jobs he can do involving his hands, and he must take regular, unpredictable breaks of between 10 and 30 minutes.

200. In *Billman*, the Court held, "outside of physically accommodating Billman, an employer would likely have to spend time and resources to train him—a person set to retire in a few years." *Id* at ¶ 39.

201. The same can be said for Arneson who is within the age of retirement and would require training in a new position.

202. Based on these facts, the Department finds that Audet's conclusion that Arneson is permanently and totally disabled is accurate.

203. However, the Department is unable to conclude that Arneson was permanently and totally disabled prior to February 3, 2020, when Dr. Holloway signed the Physical Capacities Form establishing his restrictions.

204. Arneson willingly retired from his position with Employer on June 1, 2019, without any medical restrictions in place and without asking for any accommodations.

205. He had been able to perform the job satisfactorily before retiring from the position.

206. Arneson's coworker, Kurt Hall (Hall) testified that Employer would have been willing to address accommodations he might have needed.

207. During Prado's testimony, she stated that Arneson was a good, reliable worker whose knowledge she considered a valuable asset.

208. Prior to his retirement, he had been delegating more to other staff which was something he had been encouraged to do more often.

209. She stated that he was eligible for rehire.

210. Arneson has not proven that he was permanently and totally disabled between the time he chose to leave his employment and when Dr. Holloway signed off on the restrictions.

211. Therefore, any benefits he is entitled to regarding past permanent and total disability benefits will not include the time between June 1, 2019, and February 3, 2020.

212. Arneson's past disability benefits shall be calculated from February 3, 2020, at his compensation rate of $575.16 per week.

213. Additionally, as Arneson has met his prima facie showing of permanent and total disability it is unnecessary for the Department to consider the availability of suitable employment in his community.

Conclusion:

214. Arneson has proven by a preponderance of the evidence that the electrical shock he experienced on July 18, 2018, is a major contributing cause of his condition.

215. Arneson has proven he is permanently and totally disabled and made a prima facie showing of entitlement to benefits under the odd-lot category.

216. Arneson is entitled to past disability benefits from February 3, 2020, at his compensation rate of $575.16 per week.

217. Arneson is entitled to a cost-of-living adjustment of 1.7% effective July 1, 2021, increasing his compensation rate to $584.93.

218. Arneson is entitled to a cost-of-living adjustment of 1.2% effective July 1, 2022, increasing his compensation rate to $591.95.

219. Arneson is entitled to continued cost-of-living adjustments pursuant to South Dakota law.

220. Arneson is entitled to ongoing medical and disability benefits unless, and until, Employer and Insurer can show there was a change of condition pursuant to SDCL 62-7-33.

Dated this 28 day of April, 2023.

SOUTH DAKOTA DEPARTMENT OF LABOR
AND REGULATION, DIVISION OF LABOR
AND MANAGEMENT

Michelle Faw

Michelle M. Faw
Administrative Law Judge

Regional Health

RH Lead-Deadwood Hospital
61 Charles St
Deadwood SD 57732-1303

Arneson, Michael L
MRN: 8235295, DOB: 8/24/1955, Sex: M
Adm: 7/18/2018, D/C: 7/18/2018

Attached Information — Electric Shock Injury (English)

Electric Shock Injury

When electricity passes through the body, it can damage the skin and internal organs. A strong electric shock (*high voltage*) can harm the heart, muscles, and brain. The severity of an electric shock injury depends on several factors, such as the voltage, the type of current, and the length of contact.

Most electric shock injuries that cause serious damage to the body are from a shock that is greater than 600 volts. However, just 50 volts of electricity may be enough to disrupt the heart's rhythm. Household electricity usually ranges from 110–240 volts of alternating current. A high-tension wire may be 100,000 volts or more.

What are the causes?

Common causes of this condition include:

- Contact with electricity from wires or appliances in the home.
- Children chewing and biting electric cords or playing with electric outlets.
- Getting hit by lightning.
- Workplace injury.
- Injury from a high-voltage power line.

What are the signs or symptoms?

Symptoms of this condition include:

- Tingling and numbness.
- Very bad pain.
- Muscle spasms.
- Skin burns (*thermal burns*).
- Broken bones.
- Head injury (*trauma*).
- Chest pain.
- Very fast or irregular heartbeat (*palpitations*).
- Heart attack.
- Trouble breathing, hearing, seeing, or swallowing.
- Headache.
- Confusion.
- Loss of memory.
- Jerky movements that you cannot control (*seizure*).
- Losing consciousness or passing out.

How is this diagnosed?

This condition is diagnosed based on:

- Your symptoms.
- History of receiving a shock.
- A physical exam. This may include tests to determine how badly you have been injured. You may have:
  - Blood tests to check:
    - Your blood cell counts (CBC).
    - Minerals in your blood (*electrolyte panel*).

EXHIBIT 4

- For muscle or kidney damage.
- The oxygen level of your blood.
- Electrocardiogram (ECG) to evaluate heart function.
- Urine tests to check for muscle enzymes. This would show damage to the muscles.
- Imaging studies, including:
  - X-rays of your chest or spine or both.
  - Ultrasound.
  - CT scan.

How is this treated?

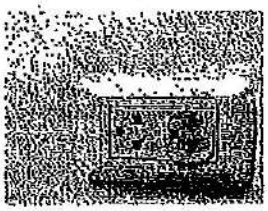
Treatment for electric shock injuries depends on the type of injury you have. Emergency treatment may include:

- IV fluids and medicines to support blood pressure.
- Oxygen and breathing support, if necessary.
- Treatment for burns, broken bones, or head injuries.
- Keeping the neck and spine from moving, if there are signs of a spine fracture.
- A long-term treatment plan, which may include surgery to treat broken bones or severe burns.

Follow these instructions at home:

- Take over-the-counter and prescription medicines only as told by your health care provider.
- Do not drive or use heavy machinery while taking prescription pain medicine.
- Follow instructions from your health care provider about how to take care of your wounds, if this applies. Make sure you:
  - Wash your hands with soap and water before you change your bandage (*dressing*). If soap and water are not available, use hand sanitizer.
  - Change your bandage as told by your health care provider.
- Keep all follow-up visits as told by your health care provider. This is important.

How is this prevented?



To prevent electric shock injuries in the future:

- Follow the manufacturer's instructions and precautions when using a home electric appliance.
- Keep electrical appliances away from the tub or shower.
- Keep electric cords out of the reach of children.
- Do not touch wet surfaces, faucets, or water pipes while using an electric appliance.
- Make sure the power is off before you work on any wires or electrical appliances.
- Use safety plugs in all electric outlets.

Contact a health care provider if:

- You develop new symptoms.
- Your symptoms change or get worse.

Get help right away if:

- You have a seizure.
- You have chest pain.
- You have trouble breathing.

Summary

- When electricity passes through your body, it can damage your skin and internal organs.
- You may undergo a variety of tests to determine how badly you have been injured.
- Treatment depends on the type of injury you have. You may require emergency treatment if you have been badly injured.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Document Released: 12/20/2004 Document Revised: 12/28/2017 Document Reviewed: 12/28/2017
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- Do not peel skin.
- Do not rub your burn, even when you are cleaning it.
- Protect your burn from the sun.

Contact a doctor if:

- Your condition does not get better.
- Your condition gets worse.
- You have a fever.
- Your burn looks different or starts to have black or red spots on it.
- Your burn feels warm to the touch.
- Your pain is not controlled with medicine.

Get help right away if:

- You have redness, swelling, or pain at the site of the burn.
- You have fluid, blood, or pus coming from your burn.
- You have red streaks near the burn.
- You have very bad pain.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Document Released: 09/26/2009 Document Revised: 02/03/2018 Document Reviewed: 05/06/2017

Regional Health

RH Lead-Deadwood Hospital
61 Charles St
Deadwood SD 57732-1303

Arneson, Michael L
MRN: 8235295, DOB: 8/24/1955, Sex: M
Adm: 7/18/2018, D/C: 7/18/2018

07/18/2018 - ED in RH Lead-Deadwood Hospital Emergency Department (continued)

Documents (continued)

Regional Health

RH Lead-Deadwood Hospital
61 Charles St
Deadwood SD 57732-1303

Arneson, Michael L.
MRN: 8235295, DOB: 8/24/1955, Sex: M
Adm: 7/18/2018, D/C: 7/18/2018

07/18/2018 - ED in RH Lead-Deadwood Hospital Emergency Department

Reason for Visit

Chief complaints: Burn and Electric Shock
Visit diagnosis: Electrical shock of hand, initial encounter

Visit Information

Admission Information

Arrival Date/Time:	07/18/2018 0848	Admit Date/Time:	07/18/2018 0848	IP Adm. Date/Time:	
Admission Type:	Urgent	Point of Origin:	Home Or Non-healthcare	Admit Category:	
Means of Arrival:	Car	Primary Service:	Emergency Medicine	Secondary Service:	N/A
Transfer Source:		Service Area:	REGIONAL HEALTH SERVICE AREA	Unit:	RH Lead-Deadwood Hospital Emergency Department
Admit Provider:	Joel Reynolds, PA	Attending Provider:	Joel Reynolds, PA	Referring Provider:	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
07/18/2018 1036	01 - Home Or Self-care	Home	Joel Reynolds, PA	RH Lead-Deadwood Hospital Emergency Department

Level of Service

Level of Service
PR EMERGENCY DEPARTMENT VISIT MODERATE SEVERITY

Medication List

Medication List

This report is for documentation purposes only. The patient should not follow medication instructions within. For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Prior To Admission

None

Discharge Medication List

None

Stopped In Visit

None

ED Provider Note

ED Provider Notes by Joel Reynolds, PA at 7/18/2018 8:48 AM

HPI:

Release Type: PATIENT ROI ID: 1249506

PHYSICAL CAPACITIES FORM

Dear Dr. Holway Patient: Mike Arneson

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient. Please note occasionally means 1-33% of the workday and frequently means 34 to 66% of the workday. Thank you for your assistance.

1. In an 8-hour workday, patient can stand/walk at one time:

0-30 minutes 30-60 minutes 1-2 hours 2-4 hours 4-6 hours 6-8 hours
Total hours during day: 0-2 2-4 4-6 6-8

2. In an 8-hour workday, patient can sit at one time:

0-30 minutes 30-60 minutes 1-2 hours 2-4 hours 4-6 hours 6-8 hours

3. In an 8-hour workday, patient can drive car/truck at one time:

10-30 minutes 30-60 minutes 1-2 hours
Total hours during day: 0-2 2-4 4-6 6-8

4. Patient can lift/carry: No restrictions

Maximum pounds: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 above
Frequently: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 above
Occasionally: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 above

5. Patient can use feet for repetitive movement as in operating foot controls:

Yes No No restrictions

6. Patient is able to:

	Never	Occasionally	Frequently	No restrictions
A. Handle		Right		Left
B. Feel		X		X
C. Finger/Fine Manipulation	X Right			X
D. Firm Grasp	X Right	X Right		X
E. Light Grasp		X Right		X
F. Push/Pull				X

7. Patient is able to:

G. Bend		X		
H. Squat		X		
I. Kneel		X		
J. Climb	X Ladders	X Stairs occasionally		
K. Reach				

8. Is patient restricted by environmental factors such as heat, cold, dust, dampness, height, noise, repetitive machinery etc.?

___ No restrictions
X Yes. Please explain Numbness of hand - loss of sensation patient cannot detect heat/cold. climbing, operating machinery dangerous due to sensory loss

9. Does patient require treatment, medication or assistive devices that might affect ability to work?

___ No restrictions
X Yes. Please explain Use caution when operating a vehicle or dangerous machinery.

10. Additional comments it heart goes into afrial Fib Mr Arneson has to stop and rest for 5min to 20min this typically occurs 3 to 4 times per week but can occur at any time.

Physician's Signature James Holway MD Date 2/3/2020

EXHIBIT 6

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

Appeal No. 30494

MICHAEL ARNESON,
Claimant/Appellant,

v.

GR MANAGEMENT, LLC, d/b/a MINERAL PALACE CASINO, Employer/Appellee
and RISK ADMINISTRATION SERVICES, INC., Insurer/Appellee.

APPELLEES' BRIEF

Appeal from the Sixth Judicial Circuit
Hughes County, South Dakota
The Honorable Christina Klinger

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NOTICE OF APPEAL FILED October 18, 2023

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

PRELIMINARY STATEMENT

Employer, GR Management, LLC, shall be referred to as "Employer." Insurer, First Dakota Indemnity Company, shall be referred to as "Insurer." Appellant, Michael Arneson, shall be referred to as "Claimant." The South Dakota Department of Labor, Workers' Compensation Division, will be referred to as the "Department." The Sixth Judicial Circuit Court, Hughes County, shall be referred to as the "Circuit Court." The Department's decision issued March 21, 2023, shall be referred to as "the Decision." The settled record transmitted by the Circuit Court shall be referenced as "SR" followed by the page number assigned by the Hughes County Clerk of Courts. Claimant's Appellant Brief shall be referred to as "AB" followed by the corresponding page number.

JURISDICTIONAL STATEMENT

On March 21, 2023, the Department issued the Decision finding that Claimant's work injury on July 18, 2018 ("the Injury") was a major contributing cause of his atrial fibrillation ("Afib"), right hand numbness, and that Claimant was permanently and totally disabled. (SR 2445–55). Employer and Insurer filed a notice of review. (*Id.* at 2106–07). On October 6, 2023, the Circuit Court issued an order affirming the Decision as to Claimant's right-hand numbness, but reversing the Department's finding that the Injury was a major contributing cause of his Afib and that Claimant was permanently and totally disabled. (*Id.* at 2568). Claimant timely filed this appeal of the Circuit Court's order on October 18, 2023. (*Id.* at 2590).

STATEMENT OF LEGAL ISSUES

There are three issues in this Appeal.

1. *Whether the Injury was a major contributing cause of Claimant's Afib.*

   The Department found that the Injury was a major contributing cause of Claimant's Afib. The Circuit Court reversed.

   Peterson v. Evangelical Lutheran Good Samaritan Soc., 2012 SD 52, 816 N.W.2d 843; *Armstrong v. Longview Farms, LLP*, 2020 SD 1, 938 N.W.2d 425; *Wagaman v. Sioux Falls Const.*, 1998 SD 27, 576 N.W.2d 237; *Rawls v. Coleman-Frizzell, Inc.*, 2002 SD 130, 653 N.W.2d, 247.

2. *Whether the Department erred in finding that the Injury was a major contributing cause of Claimant's right-hand numbness.*

   The Department found that the Injury was a major contributing cause of Claimant's right-hand numbness. The Circuit Court affirmed.

   Peterson v. Evangelical Lutheran Good Samaritan Soc., 2012 SD 52, 816 N.W.2d 843; *Armstrong v. Longview Farms, LLP*, 2020 SD 1, 938 N.W.2d 425; *Wagaman v. Sioux Falls Const.*, 1998 SD 27, 576 N.W.2d 237; *Rawls v. Coleman-Frizzell, Inc.*, 2002 SD 130, 653 N.W.2d, 247.

3. *Whether Claimant is permanently and totally disabled and entitled to benefits under the odd-lot category.*

   The Department found that Claimant was permanently and totally disabled. The Circuit Court reversed.

   SDCL 62–4–53; *Johnson v. Lennox Sch. Dist. No. 41-4*, 2002 SD 89, 649 N.W.2d 617; *Kennedy v. Hubbard Milling Co* 465 N.W.2d 792 (S.D. 1991).

STATEMENT OF THE CASE

On June 18, 2019, Claimant filed a Petition for Hearing, alleging the Injury was a major contributing cause of his AFib and right-hand numbness and he was permanently and totally disabled. (SR 90). After a hearing, the Department found Claimant established the Injury was a major contributing cause of his AFib and of his right-hand numbness. (*Id.* at 2454–55). The Department also found Claimant was permanently and totally disabled. (*Id.* at 2453). On appeal, the Circuit Court reversed in part, finding Claimant

had not shown the Injury was a major contributing cause of his AFib and that Claimant had not shown he was entitled to permanent and total disability benefits. (*Id.* at 2567). However, the Circuit Court affirmed the Department's finding that the Injury was a major contributing cause of Claimant's right-hand issues. (*Id.*).

STATEMENT OF THE FACTS

A. Claimant's educational, vocational, and medical history before the Injury on July 18, 2018.

Claimant has a GED and an associate degree in finance. (*Id.* at 364, 435). He also has a MACS license, which permits him to service electrical, heating, and air conditioning systems and to purchase and handle freon. (*Id.* at 376). Claimant is well-versed in matters related to electrical systems, plumbing, machine operation, engine rebuilds, and equipment care. (*Id.* at 365, 376). Near the beginning of his career, Claimant spent 15 years designing manufacturing machines at Atlas Mill in Wisconsin. (*Id.* at 365). Afterwards, Claimant worked as a truck driver and then started his own business offering engine rebuilding, auto repair, and machine-shop work. (*Id.*). Claimant ran that business for 15 years. (*Id.*).

Claimant also had many years of management experience before the Injury. Claimant was a mill manager for a Harley Davidson contractor, where he supervised a team of 35 people. (*Id.*). After that, Claimant supervised and led maintenance teams with Rivers Hotel Group. (*Id.*). On September 15, 2015, Employer hired Claimant as a maintenance manager. (*Id.*). Claimant was 60 years old at the time. (*Id.* at 364–65). As a maintenance manager for Employer, Claimant supervised approximately 22 maintenance personnel and casino cleaners. (*Id.* at 377). Claimant also supervised up to eight people in Employer's valet division. (*Id.*). Claimant performed some maintenance tasks himself,

but also delegated work to his employees. (*Id.* at 366, 377–79). Diana Prado ("Diana"), Claimant's supervisor, stated that Claimant was a "hard worker" and a dependable employee. (*Id.* at 411).

Because of Claimant's MACS license, familiarity with electrical, heating, and air conditions systems, and wealth of experience in maintenance and management, Employer was able to utilize Claimant for an assortment of miscellaneous tasks and could avoid bringing in outside contractors, which helped Employer keep overhead costs down.[1] (*Id.* at 376). Claimant conceded that, due to his wide range of skill and experience, Employer could not easily replace him. (*Id.* at 379).

Before the Injury, Claimant was a pack-a-day smoker for "30 plus years." (*Id.* at 376). Claimant sought treatment for smoker's cough and decreased lung capacity long before he began working for Employer in 2015. (*Id.* at 1448–51). Claimant continued to seek treatment for his cough and smoking-related diseases after he began working for Employer. (*Id.* at 1454–60).

B. July 18, 2018, to June 28, 2019: the Injury, Claimant's resignation, and the Petition for Hearing.

The Injury occurred on July 18, 2018, when Claimant turned on a switch for an exhaust fan at work, causing a short. (*Id.* at 367–68). Claimant initially felt nothing. (*Id.* at 367). However, his hand started to tingle, and when he removed his glove, he noticed his three middle fingers were singed. (*Id.*). Claimant decided to go to the emergency room to be examined. (*Id.* at 369).

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[1] Although Employer sometimes contracted work outside of the company, Claimant admitted that Employer never turned him down when he asked for help from outside contractors. (*Id.* at 377).

At the hospital, Claimant did not report suffering from heart palpitations or shortness of breath. (*Id.* at 382, 517). Nonetheless, Claimant's medical providers ordered an electrocardiogram ("EKG") his heart, which was normal. (*Id.* at 486, 518, 521). Claimant was discharged from the hospital and returned to work full-time for Employer. (*Id.* at 369).

In the days following the Injury, Claimant did not report any heart issues to his medical providers, and his medical record showed no evidence of heart issues. (*Id.* at 382). However, Claimant later testified that he began having heart palpitations several days after the Injury but wrote them off as a "fluke." (*Id.* at 369).

Two days after the Injury, on July 20, 2018, Claimant was riding his motorcycle when he felt "some slight numbness in his fingertips." (*Id.* at 1325). Dr. Zachary Jager ("Dr. Jager") treated Claimant at the clinic and noted that Claimant had blisters on his hands that were healing. (*Id.*). He also noted Claimant could flex and extend his fingers and had full range of motion. (*Id.*). Claimant did not complain of any heart issues during this visit, and Dr. Jager noted Claimant had no cardiovascular symptoms. (*Id.* at 1325–27). Dr. Jager advised that Claimant's symptoms may be related to carpal tunnel syndrome. (*Id.* at 1325, 2434–35). On July 24, 2018, Claimant completed a report on the Injury. (*Id.* at 2435). The report made no reference to any heart problems. (*Id.*).

About a week later, on July 30, 2018, almost two weeks after the Injury, Claimant experienced chest pain, dizziness, and shortness of breath. (*Id.* at 545, 2435). Claimant was sent to the intensive care unit. (*Id.*). The next day, Claimant visited his treating doctor, Dr. James Holloway ("Dr. Holloway"), for an evaluation. (*Id.* at 2435). After reviewing Claimant's medical records, Dr. Holloway diagnosed Claimant with

hyperthyroidism and AFib. (*Id.*). AFib is an abnormal heart rhythm. (*Id.* at 2407). Hyperthyroidism refers to a condition in which the body overproduces thyroid hormones. (*Id.* at 2349). Dr. Holloway noted Claimant "undoubtedly" had hyperthyroidism for some time before to the Injury. (*Id.* at 748). Hyperthyroidism would explain Claimant's heart palpitations, which Claimant initially thought were a "fluke." (*Id.* at 419–20).

Dr. Holloway also took an EKG of Claimant's heart, which again showed Claimant's heart dimensions were normal, and pumping and relaxation were normal. (*Id.* at 708). Dr. Holloway concluded that if Claimant got his hyperthyroidism under control, it would help control his Afib. (*Id.*). Claimant was discharged and began treatment for hyperthyroidism. (*Id.* at 728–31). Several weeks later, Dr. Holloway diagnosed Claimant with Graves' disease. (*Id.* at 2436). Graves' disease is a condition in which the body stimulates the thyroid to overproduce thyroid hormones, which causes hyperthyroidism when thyroid hormones become excessive. (*Id.* at 2354).

When Claimant returned to work after the Injury, he did not have any problems completing his regular duties. (*Id.* at 369, 411–12). After Claimant was diagnosed with AFib and hyperthyroidism, Employer's General Manager, Frank Gould ("Frank"), testified Claimant seemed fine. (*Id.* at 211–12). Although Claimant continued to perform his regular duties after the Injury without issue, Diana, Claimant's supervisor, encouraged him to delegate more. (*Id.* at 411).

By December 2018, Dr. Holloway noted that Claimant's thyroid levels were now normal. (*Id.* at 829). Dr. Holloway also noted Claimant had not had any new episodes of AFib since he began his thyroid medication. (*Id.*). At that time, Dr. Holloway noted Claimant's "hyperthyroidism predispose[d] him to atrial fibrillation." (*Id.*). Claimant also

reported he had increased energy levels and no unusual tiredness or fatigue. (*Id.* at 2436). In January 2019, Claimant was given a heart monitor for a continuous 48-hour period. (*Id.*). The results of the monitoring were normal, and Claimant reported he did not have any heart-related symptoms at that time. (*Id.*).

Claimant did not report any heart issues again until March 2019, when he stated he was having heart palpitations. (*Id.*). He felt these palpitations around the same time he forgot to take his thyroid medication. (*Id.*). Claimant's providers advised him not to miss any further doses and to remain on his medications. (*Id.*).

Several months later, on June 1, 2019, Claimant retired from Employer. (*Id.*). Frank was surprised by Claimant's decision to retire because Claimant performed his job well. (*Id.* at 212–13). Diana was also surprised by Claimant's decision to retire. (*Id.* at 412). Diana stated Claimant was a valuable employee, and he remained eligible for rehire. (*Id.* at 411–13). Diana further stated that if Claimant needed restrictions to keep working, Employer would have accommodated those restrictions indefinitely. (*Id.* at 412).

Claimant filed a Petition for Hearing less than a month later, alleging the Injury was a major contributing cause of his AFib, right-hand numbness, and that he was permanently and totally disabled. (*Id.* at 90).

C. June 2019 to March 21, 2023: developments in Claimant's health, expert testimony, and the Administrative Hearing.

Claimant's health was stable after he retired. In June 2019, after his retirement, Claimant drove his motorcycle with his significant other from Rapid City to Red Lodge, Wyoming, which was over a six-hour ride. (*Id.* at 387). Then Claimant rode to Cody, Wyoming, which was a 15-hour ride, before returning home to Rapid City. (*Id.*).

Claimant also did mechanical work on his significant other's and friend's vehicles after his retirement. (*Id.* at 385–86). Further, after this retirement and until August 16, 2020, Claimant took his thyroid medication consistently and his AFib was generally well-controlled. (*Id.* at 982–1168). During this time, Claimant was not fatigued. (*Id.*).

Dr. Richard Brody ("Dr. Brody"), cardiologist

In the spring of 2020, Employer and Insurer retained Dr. Brody to perform a review of Claimant's medical records and provide an opinion on whether the Injury was a major contributing cause of Claimant's AFib. (*Id.* at 2426). Dr. Brody is certified in internal medicine by the American Board of Internal Medicine and certified in cardiology by the American Board of Cardiovascular Diseases. (*Id.* at 2424). Dr. Brody is the only cardiologist to provide expert testimony in this case.

Dr. Brody has over 40 years of medical education and experience in treating and diagnosing cardiac symptoms. (*Id.* at 2406–07, 2424–25). Dr. Brody graduated from the University of Minnesota medical school in 1983. (*Id.* at 2406). He went on to practice internal medicine as an intern in Boston for one year. (*Id.*). Dr. Brody then served as a resident of Internal Medicine for two years and then as a fellow in cardiovascular medicine for another two years. (*Id.*). Dr. Brody returned to Minneapolis to complete another cardiology fellowship, which he completed in 1989. (*Id.*). Since then, Dr. Brody has practiced cardiology in St. Paul, Minnesota. (*Id.* at 2406–07). From his nearly 40-year career in cardiology, Dr. Brody is extremely well-versed in the effect of electrical shock injuries on the heart and has treated many patients with AFib. (*Id.* at 2407). Dr. Brody testified that 32% of the patients he saw in the last two months sought treatment for AFib. (*Id.*).

Dr. Brody reviewed Claimant's deposition, South Dakota Employer's First Report of Injury, and Claimant's medical records. (*Id.* at 2426). Dr. Brody also reviewed medical literature on the relationship between electrical shocks and AFib. (*Id.* at 2430). In his report, Dr. Brody opined the Injury was NOT a major contributing cause of Claimant's AFib. (*Id.* at 2429–31). Dr. Brody explained that, based on the medical literature, AFib develops after an electric shock "only very rarely." (*Id.* at 2430). In fact, Dr. Brody reported there were only three or four reported cases of electrical-shock induced AFib in the medical literature "dating back to 1954," and there were "no case reports [in the medical literature] describing electrocution-induced atrial fibrillation that occurred 12 days after an electrical injury," as in Claimant's case. (*Id.* at 2430). Because electrocution-induced AFib is almost nonexistent in the medical literature, Dr. Brody concluded that Claimant's AFib "was likely secondary to hyperthyroidism." (*Id.*).

In January 2021, Dr. Brody also testified by deposition and affirmed the conclusions in his written report. (*Id.* at 2406, 2409–10). Before his deposition, Dr. Brody reviewed Claimant's most recent medical records as well as the medical literature on the relationship between electric shocks and Afib. (*Id.* at 2409–10). After this review, Dr. Brody confirmed there were very few case studies of electrocution-induced AFib in the medical literature. (*Id.*). Additionally, since he had produced his written report, Dr. Brody stated he found just one article in which a patient developed AFib sometime after receiving a low-voltage electric shock. (*Id.* at 2010). "But even in that particular article [the electric shock and AFib] might not be related. . . . [The article's authors] didn't really comment on whether [the AFib] was caused by the electrical shock." (*Id.*). Further, in that article, the authors concluded "that the prevalence of atrial fibrillation after an

electrical shock" was 0.6%. (*Id.*). Dr. Brody explained that, in documented cases where AFib developed after a patient received an electric shock, the AFib "resolved within 24 hours." (*Id.).*

In contrast, Dr. Brody testified that hyperthyroidism is a well-documented precursor to AFib, and that the "association" between hyperthyroid and AFib "is a lot stronger than the association with electric shock and atrial fibrillation." (*Id.* at 2409–10). Dr. Brody testified that about 10% to 15% of patients with hyperthyroidism will develop Afib, in contrast to the .6% of electric shock patients who develop AFib. (*Id.* at 2414).

Dr. Brody also found it significant that, on the date of the Injury, and when Claimant reported to the hospital 12 days later, Claimant's EKG showed a normal heart rhythm and no evidence of structural heart damage. (*Id.* at 2408, 2411). Based on the normal, healthy appearance of Claimant's heart, Dr. Brody opined the Injury had not created any structural heart damage that could account for Claimant's AFib. (*Id.* at 2410–11). Based on the foregoing, Dr. Brody opined Claimant's hyperthyroidism had a much higher probability of inducing AFib than the Injury and that the Injury was not a major contributing cause of Claimant's AFib. (*Id.* at 2409–11).

Dr. Holloway, internist

Claimant retained Dr. Holloway, his treating provider, as his sole medical expert. Dr. Holloway practices internal medicine in the Lead-Deadwood area. (*Id.* at 2381).

Dr. Holloway testified by deposition on September 18, 2020. (*Id.* at 277). Importantly, in giving his opinion, Dr. Holloway did not review Dr. Brody's written report. (*Id.* at 285, 2406). To prepare for his deposition, Dr. Holloway also claimed he reviewed publications on the relationship between electric shocks and Afib, but Dr.

Holloway could not point to any specific publication beyond one online source. (*Id.* at 285).

Dr. Holloway concluded the Injury was a major contributing cause of Claimant's AFib. (*Id.* at 281). In reaching his opinion, Dr. Holloway first considered whether Claimant's hypothyroidism could have caused his AFib. Like Dr. Brody, Dr. Holloway agreed that hyperthyroidism is "clearly . . . a predisposing factor" to AFib. (*Id.* at 2356). Dr. Holloway also agreed that Claimant's hyperthyroidism preceded the Injury and Claimant's development of AFib. (*Id.* at 2354). Like Dr. Brody, Dr. Holloway stated the association of hyperthyroidism and AFib is such that about 10% of patients with hyperthyroidism, or between 5% to 15% of patients, will also develop AFib. (*Id.* at 2349).

However, Dr. Holloway ultimately concluded that Claimant's hyperthyroidism was not a major contributing cause of AFib because his AFib occurred near the Injury and because hyperthyroid-induced AFib is relatively rare. (*Id.*). Dr. Holloway provided ***no*** medical explanation for his belief that electrocution-induced AFib is a likelier cause of Claimant's AFib than hyperthyroidism, which is a medically established precursor to AFib for a notable portion of hyperthyroid patients. (*Id.*). Instead, Dr. Holloway stated:

> My opinion is based primarily on the fact that the majority of people with hyperthyroidism do not develop atrial fibrillation. ***If [Claimant] had just come to your office and never had an electrical injury and happened to have the two*** **[hyperthyroidism and AFib]** ***together, you could link it as an association.*** But, again, only about 10 percent of people with hyperthyroidism develop atrial fibrillation. [Claimant] had an electrical shock which we know causes electrical instability, palpitations, extra beats, which can trigger atrial fibrillation. So my opinion is that absent the electrical shock, it is more likely than not that [Claimant] would not have had atrial fibrillation. Why? Because the vast majority of patients with hyperthyroidism alone do not develop atrial fibrillation.

(*Id.*). Dr. Holloway did not explain the medical basis for his conclusory claim that "electrical instability, palpitations, extra beats" caused by electric shocks, in turn "trigger atrial fibrillation." (*Id.*). Neither did Dr. Holloway explain the strength of the association between electric shocks and AFib in his deposition, *i.e.*, what percentage of patients who experienced an electric shock will develop AFib. (*Id.*). Further, on cross-examination, Dr. Holloway admitted he did not have evidence for his claim that electrical shocks may cause AFib. When asked to provide a time span in which an electric shock could be expected to cause AFib, Dr. Holloway admitted he had no medical evidence to answer the question. (*Id.* at 2359). Again, Dr. Holloway was not a cardiologist. (*Id.* at 2381).

Dr. Holloway also testified the Injury caused Claimant's hand symptoms of numbness and loss of feeling. (*Id.* at 2349–50, 2448). He stated the electric shock could have caused nerve damage that accounted for Claimant's symptoms. (*Id.*).

Around the time Dr. Holloway was deposed, in August 2020, Claimant discontinued his thyroid medication because it gave him a rash. (*Id.* at 1169). Before Claimant discontinued his thyroid medication, he felt great, did not suffer from significant palpitations, slept well, and reported no unusual fatigue or tiredness. (*Id.* at 1102, 1106, 1148). Soon after Claimant discontinued his thyroid medications, he became chemically hyperthyroid and suffered an increase in heart palpitations. (*Id.*). Even though Dr. Holloway opined in his September 2020 deposition that Claimant's hyperthyroidism and AFib were unrelated, that same month, Dr. Holloway noted in Claimant's medical records that Claimant's heart palpitations had increased because Claimant stopped taking his thyroid medications. (*Id.*).

Administrative Hearing

The Department held a hearing on September 14, 2022. (*Id.* at 2221). At the hearing, Claimant relied on the 2020 deposition of Dr. Holloway in support of his claim that the injury was a major contributing cause of his AFib. (*Id.* at 2222–23). Again, at the time of the deposition, Dr. Holloway did not review Dr. Brody's written report or deposition, or review any of Claimant's medical records after September 2020. (*Id.* at 2353).

Claimant testified at hearing. (*Id.* at 359). Right after the Injury, Claimant testified that his thumb, right index, finger and right middle finger were numb from the knuckles down. (*Id.* at 371). At the time of hearing, Claimant testified that the numbness and lack of sensation on this thumb, right index, and right middle fingers had worsened to the extent that he no longer feel them and such that he "cannot do any [thing] fine." (*Id.* at 373). He stated that he could no longer feel his thumb, right index, and middle fingers when he shook hands, held a pen, or cut himself, and it impacted his ability to drive a motorcycle. (*Id.* at 373, 386).

Employer and Insurer presented Dr. Brody's written report and deposition testimony in support of their argument that the Injury was not a major contributing cause of Claimant's AFib. (*Id.* at 2222, 2226). Additionally, Employer and Insurer introduced Dr. Bruce Elkins ("Dr. Elkins") to provide another expert opinion on causation. (*Id.* at 2223).

Dr. Elkins, occupational medicine

Dr. Elkins is board certified in preventive medicine and occupational medicine. (*Id.* at 415). He graduated from the University of Wisconsin medical school in 1993.

(*Id.*). After graduation, he completed residencies in prevention medicine and occupational medicine. (*Id.*). Dr. Elkins practiced occupational medicine in Bettendorf, Iowa until 2004, when he became Medical Director for Occupational Medicine at Avera in Sioux Falls. (*Id.* at 1662). Dr. Elkins practiced at Avera for 12 years. (*Id.).* He then practiced at the Sioux Falls V.A. Hospital. (*Id.*). Dr. Elkins has provided opinions as both a treating doctor and an IME provider. (*Id.* at 415). As a treating physician, he had treated electrical injuries. (*Id.* at 416).

Before providing his testimony, Dr. Elkins reviewed all of Claimant's available medical records. (*Id.*). He also reviewed Dr. Holloway's deposition and Dr. Brody's deposition and written report. (*Id.*). Like Dr. Brody, Dr. Elkins also researched and reviewed medical literature on the relationship between Graves' disease, hyperthyroidism, electrical shock injuries, and the incidence of arrhythmias caused by both hyperthyroidism and electrical injuries. (*Id.* at 416–19).

Like Dr. Brody, Dr. Elkins determined the Injury was not a major contributing cause of Claimant's AFib. (*Id.* at 423). Like Dr. Brody, Dr. Elkins concluded that if Claimant sustained heart damage from the Injury, he would have had symptoms of heart damage immediately after the Injury. (*Id.* at 422). But Claimant's medical records revealed no sign of heart damage or arrhythmia after the Injury that could potentially explain why he developed AFib. (*Id.*).

Like Dr. Brody, Dr. Elkins also found the likelihood that Claimant developed AFib from the Injury was exceedingly remote. (*Id.* at 423). Dr. Elkins found there would be approximately a 1 in 1,000 chance that the Injury caused Claimant's AFib. (*Id.*). In contrast, Dr. Elkins testified Graves' disease and hyperthyroidism are precursors to AFib

in approximately 1 in 10 hyperthyroid patients. (*Id.*). Based on the medical research, Dr. Elkins testified there is about a 100-times greater likelihood Claimant's AFib was caused by Claimant's hyperthyroidism than the Injury. (*Id.* at 420). This testimony was not disputed. Because Claimant's hyperthyroidism was over 100 times more likely to have caused his AFib than the Injury, Dr. Elkins opined the Injury was not a major contributing cause of Claimant's AFib. (*Id.* at 423). In further support of his opinion, Dr. Elkins stated Claimant's age and demographic characteristics likely made his risk of developing AFib from hyperthyroidism higher than the general population. (*Id.* at 420).

Additionally, like Dr. Brody, Dr. Elkins presented unrefuted testimony that, in the rare cases in which electric shocks are associated with irregular heartbeats or "arrhythmias," the "[c]ardiac arrythmias due to electrical injuries are usually observed during or immediately after the event" and resolve shortly thereafter. (*Id.* at 1694). Therefore, "it is unlikely that the patient will go on to develop cardiac problems [from the shock], and it is not necessary to monitor the patient for 24 hours." (*Id.*). One study "reported that all patients with [arrhythmias] resolved within 48 hours of admission." (*Id.*)

Next, Dr. Elkins testified the Injury was not a major contributing cause of Claimant's hand numbness, "with only the possible exception [of] some numbness in the fingertips." (*Id.* at 424). Relying on Claimant's medical records and Claimant's testimony at hearing, Dr. Elkins explained that Claimant's current hand symptoms were very different from his symptoms after the Injury. (*Id.*). After the Injury, Claimant complained of burns on his hand and some numbness in his fingertips. *(Id.*). However, at hearing, Claimant testified that he could not use his thumb or feel if his fingers are holding

something. (*Id.*). Dr. Elkins opined that those symptoms are "not consistent with an electrical injury," and he could provide no medical explanation for why an electric injury could cause "delayed . . . incoordination, weakness, and loss of movement in [Claimant's] thumb." (*Id.*). Instead, Dr. Elkins, like Dr. Jager, opined that carpal tunnel syndrome could account for Claimant's symptoms. (*Id.* at 2448).

At the hearing, Employer and Insurer also presented the testimony of James Carroll ("Carroll") as a vocational expert. (*Id.* at 360). Claimant presented the testimony of Tom Audet ("Audet") as his vocational expert. (*Id.* at 359).

Carroll, vocational consultant

Carroll has a bachelor's degree in psychology, a master's degree in counseling, and has been in the vocational rehabilitation field for 43 years. (*Id.* at 433). Carroll worked as a Vocational Rehabilitation Counselor for Ohara, LLC, in Sioux Falls. (*Id.*). However, he also performed vocational rehabilitation work in South Dakota, Nebraska, and Iowa. (*Id.*). He worked on both plaintiff and defense cases, and most of his files are West River files. (*Id.*). He checked the Black Hills labor market on a near-daily basis. (*Id.*).

Before providing his opinion, Carroll reviewed Claimant's medical records, vocational history, and educational history. (*Id.*). Carroll also performed a transferable skills analysis, and examined Claimant's local labor market to determine what jobs were available in his area. (*Id.*). Carroll also contacted Diana, Claimant's former supervisor, to inquire if Employer would have a position available for Claimant if he returned to work. (*Id.* at 2297).

Carroll first noted that in Claimant's labor market, and in South Dakota generally, there is a worker shortage and employers struggle to find qualified employees. (*Id.* at 2297–99). Carroll also opined that Claimant's education and work history made him employable and a highly marketable applicant. (*Id.* at 2298). In particular, he noted that Claimant's associate degree in finance made him marketable for sedentary, light duty work and that Claimant's management experience was highly marketable. (*Id.*). He further noted that, due to the worker shortage in Claimant's geographic area, employers would be willing to accommodate Claimant's current restrictions for fatigue and limited use of his right hand, and Claimant would not have issues finding a job paying at or above his work comp rate. (*Id.* at 2298–2300). Carroll identified eight job openings in Claimant's area for which he was qualified and that would pay at or above Claimant's work comp rate. (*Id.* at 436–37, 1872–83). Based on his conversation with Diana, Carroll also opined that Employer would have hired Claimant back if Claimant was willing. (*Id.* at 2300).

Audet, vocational expert

Audet is a certified vocational rehabilitation counselor. (*Id.* at 2256). Audet serves as a vocational expert in Social Security disability hearings. (*Id.*). He devotes approximately 40-50% of his practice to workers' compensation. (*Id.* at 2265). Audet admitted that he has testified on behalf of the claimant in ***every* workers' compensation case** he has ever taken. (*Id.*).

Audet opined Claimant may have to take breaks at work if he had an AFib episode, which limited his ability to find a job or stay employed in a position that would pay as much as Claimant's work comp rate. (SR 2260–61). Additionally, Audet opined

that Claimant's self-reported right-hand "problem[s]," "fatigue" issues, and age would make it difficult to find gainful employment. (*Id.* at 2261). Audet opined the combination Claimant's right-hand limitations, fatigue issues, Afib, and age made him permanently and totally disabled. (*Id.*).

D. The Decision

The Department found the Injury was a major contributing cause of Claimant's right-hand numbness and AFib. (*Id. at* 2445–55). It also found that Claimant was permanently and totally disabled. (*Id.*).

As to AFib, the Department first found that the medical experts in this case—Dr. Brody, Dr. Holloway, and Dr. Elkins—had adequate foundations for their opinions. (*Id.* at 2445). The Department then briefly acknowledged Dr. Brody's and Dr. Elkins's testimony "that it was very rare for [AF]ib to be caused by an electrical shock." (*Id.* at 2446). Nonetheless, the Department accepted Dr. Holloway's testimony that the Injury was a major contributing cause of Claimant's AFib. (*Id.* at 2446–47). The Department did not explain why it accepted Dr. Holloway's testimony in the face of unrebutted medical evidence that the Injury was approximately 100 times less likely to account for Claimant's AFib than hyperthyroidism. (*Id.*).

Turning to Claimant's right-hand numbness, the Department acknowledged Claimant's "numbness was not the same it when it first started" after the Injury, "but it was still present." (*Id.* at 2447). The Department accepted Dr. Holloway's testimony that the Injury had caused unhealed nerve damage that caused Claimant's right-hand numbness, even though Dr. Holloway provided that testimony over two years before.

(*Id.* at 2448). As such, the Department concluded that the Injury was also a major contributing cause of Claimant's right-hand numbness. (*Id.* at 2448–49).

Finally, the Department found Claimant was permanently and totally disabled. (*Id.* at 2449–54). Based on Claimant's work restrictions and age, the Department concluded Claimant was obviously unemployable. (*Id.*). In reaching this conclusion, the Department did not address Employer's unrebutted evidence that it would have rehired Claimant and accommodated his work restrictions.[2] (*Id.*). After concluding that Claimant had established a prima facie case of permanent and total disability, the Department also did not consider whether Employer and Insurer had shown that they had found Claimant suitable employment opportunities or that, had Claimant not retired, he would still be working for Employer. (*Id.* at 2452–54).

Employer and Insurer timely appealed to the Circuit Court, which reversed the Decision in part. (*Id.* at 2568). The Circuit Court found Employer and Insurer presented unrefuted testimony that the incidence of electrocution-induced AFib is extremely low, between .1 percent and .6 percent. (*Id.* at 2463–65). Meanwhile, there was unrefuted evidence that the incidence of hyperthyroid-induced AFib was between 10%–15%. (*Id.* at 2565). The Circuit Court concluded Claimant had shown it was "possible" the Injury caused his Afib, but "possibility [was] not sufficient to establish the standard of probability necessary" to show that the Injury was a major contributing cause of Claimant's AFib. (*Id.*). Therefore, the Circuit Court found the Department committed an

[2] The Department found Claimant was not totally and permanently disabled at the time he resigned because many of Claimant's current work restrictions did not exist at that time, but he became permanently and totally disabled when his current work restrictions were put in place on February 3, 2020. (*Id.* at 2453–54).

error in law by concluding the Injury was a major contributing cause of Claimant's Afib. (*Id.*).

As to Claimant's right-hand numbness, the Circuit Court affirmed the Decision. (*Id.* at 2565–66). Briefly, the Circuit Court stated it was persuaded by Dr. Holloway's[3] testimony that an electrical-shock injury, such as the Injury, could explain Claimant's currents symptoms of numbness and lack of sensation. (*Id.*).

As to whether Claimant was permanently and totally disabled, the Circuit Court found Claimant was employable and thus the Department erred by concluding to the contrary. (*Id.* at 2566–67). Specifically, the Circuit Court found it significant Claimant continued to work for almost a year after his Injury without issue, and Diana, his supervisor, testified that he was eligible for rehire. (*Id.* at 2566). Further, the Circuit Court found the Department made an error in law by finding Claimant permanently and totally disabled when he had voluntarily resigned from Employer and when Employer had shown he was eligible for rehire. (*Id.* at 2566–67).

STANDARD OF REVIEW

The South Dakota Supreme Court "review[s] the Department's decision in the same manner as the circuit court." *Hughes v. Dakota Mill & Grain, Inc.*, 2021 SD 31, ¶ 12, 959 N.W.2d 903, 907 (citing SDCL 1-26-37). The Court gives the Department's factual findings "great weight" and overturns those finding only if "clearly erroneous." (*Id.*). The Department's factual findings are "clearly erroneous" if, "after reviewing the

[3] The Circuit Court also stated that Dr. Brody had opined the Injury was a major contributing cause of Claimant's right-hand numbness. (*Id.* at 2565). However, Dr. Brody declined to provide an opinion on Claimant's hand stating such an opinion would be outside of his area of expertise. (*Id.* at 2431).

evidence," the Court is "left with a definite and firm conviction that a mistake has been made." (*Id.*). However, when the Department "makes factual determinations on the basis of documentary evidence, such as depositions or medical records[,]" the standard of review is de novo. *Baker v. Rapid City Reg'l Hosp.*, 2022 SD 40, ¶ 29, 978 N.W.2d 368, 378. The Supreme Court applies this less deferential standard of review to documentary evidence because findings of fact thereon are "based entirely upon . . . review of the same record" before the Supreme Court. *Kurtz v. SCI*, 1998 SD 37, ¶ 10, 576 N.W.2d 878, 882. "The Department's conclusions of law are reviewed de novo. Mixed questions of law and fact are also fully reviewable." *May v. Spearfish Pellet Co., LLC*, 2021 SD 48, ¶ 8, 963 N.W.2d 761, 764. "Ultimately, the Claimant retains the burden of proving all facts essential to compensation." *Kuhle v. Lecy Chiropractic*, 2006 SD 16, ¶ 16, 711 N.W.2d 244, 247.

ARGUMENT AND ANALYSIS

A. The Injury was not a major contributing cause of Claimant's AFib.

i. De novo review applies.

Claimant argues this Court should review the Department's determination that the Injury was a major contributing cause of Claimant's AFib under the clear error standard. (AB 19). This is incorrect. Here, the Department's determination was based on Dr. Holloway's deposition testimony. (SR 2556). Therefore, the Court reviews the Department's determination that the Injury was a major contributing cause of Claimant AFib *de novo*. *See Peterson v. Evangelical Lutheran Good Samaritan Soc.*, 2012 SD 52, ¶ 19, 816 N.W.2d 843, 849 (holding that when the "Department entered its causation

findings on medical records and depositions, . . . we review the Department's findings de novo").

ii. Claimant cannot meet his burden of showing the Injury was a major contributing cause of AFib by a preponderance of the evidence.

To receive workers' compensation benefits, Claimant must show that: (1) the Injury "ar[ose] out of and in the course of [his] employment," and (2) that Claimant's "employment or employment related activities are a major contributing cause of the condition" of which he seeks compensation. SDCL 62-1-1(7); *Steinberg v. South Dakota Dep't of Military Veterans Affairs*, 2000 SD 36, ¶ 9, 607 N.W.2d 596, 599. "A major contributing cause" is "not the only cause, not the most significant cause, just a major contributing cause." *Hughes v. Dakota Mill and Grain, Inc.*, 2021 SD 31, ¶ 22, 959 N.W.2d 903, 910. "Expert witness testimony must be used to establish the causal connection between one's employment and subsequent injury where the field is one in which laymen are not qualified to express an opinion." *Hanten v. Palace Builders, Inc.*, 1997 SD 3, ¶ 10, 558 N.W.2d 76, 78.

Concerning the sufficiency of expert testimony, this Court has repeatedly stated that "[t]he evidence necessary to support an award," expert or otherwise, "must not be speculative, but rather must be precise and well supported." *Vollmer v. Wal-Mart Store, Inc.*, 2007 SD 25, ¶ 14, 729 N.W.2d 377, 382. Further, such expert testimony must establish "proof of causation . . . to a reasonable degree of medical probability, not just possibility." *Armstrong v. Longview Farms, LLP*, 2020 SD 1, ¶ 23, 938 N.W.2d 425, 431. When considering expert testimony, a court "is free to accept all of, part of, or none of, an expert's opinion." *Wagaman v. Sioux Falls Const.*, 1998 SD 27, ¶ 18, 576 N.W.2d 237, 241. A court properly discounts or discards an expert opinion that is not based on

medical evidence. *See id.* at ¶ 43, 576 N.W.2d at 244. As this Court has repeatedly recognized, "an expert's opinion is entitled to no greater weight than the facts upon which it is based." (*Id.*).

Further, this Court has specifically held that evidence a workplace injury preceded a claimant's symptoms is insufficient to establish medical causation as a matter of law. *See Rawls v. Coleman-Frizzell, Inc.*, 2002 SD 130, ¶ 20, 653 N.W.2d, 247, 252. This rule is based upon "the axiom *post hoc, ergo propter hoc*" or "the fallacy of confusing sequence with consequence." (*Id.*). (emphasis in original and citations omitted). As this Court has recently explained, an expert causation opinion relying only on the fact that a claimant's symptoms changed after an injury "does not constitute medical evidence because it does not explain how Claimant's injury contributed independently to Claimant's condition, especially [when] considering that Claimant was already suffering the effects of [a pre-existing condition that could account for claimant's current symptoms] at the time of his injury." *Armstrong*, 2020 SD 1, ¶ 32, 938 N.W.2d at 433. In other words, expert testimony on causation must show the *mechanism* by which a workplace injury caused the claimant's current condition to support a request for benefits. (*See id.*).

Here, Dr. Brody and Dr. Elkins provided unrebutted expert testimony that, crucially, was based on a thorough review of Claimant's medical records and medical literature on the association between electric shocks and AFib. Dr. Brody's opinion was based on his 40 years of experience as a cardiologist, during which he treated many AFib patients, as well as his review of medical literature. (*Id.* at 2406–07, 2424–25, 2430). Likewise, Dr. Elkins's opinion was based on his review of medical literature and his

experience as a practitioner. (*Id.* at 416–19). The Court has held that "uncontradicted or undiscredited expert testimony. . . should not [be] arbitrarily disregard[ed]." *Kennedy v. Hubbard Milling Co.*, 465 N.W.2d 792, 795 (S.D. 1991).

Dr. Brody provided unrefuted testimony that, from his review of 70 years of medical literature, there were only three or four cases studies of electrocution-induced AFib. (*Id.* at 2409–10, 2430). Further, in these case studies, the AFib resolved itself with 24 hours of the electric shock. (*Id.* at 2410). Likewise, Dr. Elkins provided unrefuted testimony that there is about a 1 in 1,000 medical probability that an electrical injury will induce AFib, while there is about a 1 in 10 probability hyperthyroidism induces Afib. (*Id.* at 420, 423). Put differently, treating hyperthyroidism and electrical shock as the only two causes of AFib, Dr. Elkins put likely cause of AFib 100:1 in favor of hyperthyroidism. (*Id.* at 420). Additionally, Dr. Elkins confirmed that in virtually all cases of electric shock-induced arrhythmias, the arrhythmias resolved within 24 hours of the shock. (*Id.* at 1694).

Additionally, as Dr. Brody and Dr. Elkins noted, Claimant's heart showed no evidence of damage after the Injury. (*Id.* at 422; 2408–11). Without evidence of damage to the heart, or any other medical evidence on the causal relationship of electric shock to AFib, there is no medical basis to conclude that the Injury was a major contributing cause of Claimant's AFib. (*Id.*). Again, evidence that AFib arose after the Injury alone does not prove the Injury was a major contributing cause of Claimant's AFib as a matter of law. *See Rawls*, 2002 SD 130, ¶ 20, 653 N.W.2d at 252 (discussing "the axiom *post hoc, ergo propter hoc*" or "the fallacy of . . . confusing sequence with consequence").

Claimant attempts to refute Dr. Brody's and Dr. Elkins's testimony by asserting they lacked expertise in hyperthyroidism and Claimant's medical history and are thus uncredible. (AB 19–24). This is plainly untrue. As the Department noted, Dr. Brody and Dr. Elkins were qualified to provide opinions because they were trained and experienced in their respective medical fields, reviewed Claimant's medical records, and researched medical literature before providing opinions. (*Id.* at 2445). Further, this Court has long held that a nontreating physician's opinion can be more persuasive than the opinion of a treating physician on causation. *See News Am. Mktg. v. Schoon*, 2022 SD 79, ¶¶ 40–41, 984 N.W.2d 127, 139.

More specifically, Claimant also argues that Dr. Elkins did not have a sufficient basis for his testimony that the probability of electrocution induced AFib is 1 in 1,000 and that Dr. Elkins "pulled" this statistic "out of thin air." (AB 31). This is also untrue. Dr. Elkins testified that he obtained that estimate from his review of medical studies on the relationship between electrical shocks and AFib in preparation for his deposition testimony. (SR 2283). This testimony was not refuted or challenged at hearing.

Next, Claimant argues that Dr. Holloway's testimony was persuasive and sufficient to establish that the Injury was a major contributing cause of his AFib. (*See* AB 19–25). But Dr. Holloway's testimony cannot refute Dr. Brody's and Dr. Elkins's opinions for several reasons.

First, in his deposition, Dr. Holloway presented no medical explanation or evidence for his conclusion that electric shock cause AFib. (*Id.* at 2349, 2359). To the contrary, Dr. Holloway admitted that his opinion was based only on the fact that Claimant's AFib developed *after* the Injury. (*Id.*) As discussed, this is insufficient. *See*

Rawls, 2002 SD 130, ¶ 20, 653 N.W.2d, at 252 (discussing "the fallacy of confusing sequence with consequence"); *Armstrong*, 2020 SD 1, ¶ 32, 938 N.W.2d at 433 (holding that the appearance of a condition after a workplace injury "does not constitute medical evidence because it does not explain how Claimant's injury contributed independently to Claimant's condition," especially when a claimant had a preexisting condition)."An expert's opinion is entitled to no greater weight than the facts upon which it is based." *Wagaman,* 1998 SD 27, ¶ 43, 576 N.W.2d at 244. *See also* SDCL 62-1-15 (stating that "evidence concerning any injury shall be given greater weight if supported by objective medical findings"). Therefore, here, where Dr. Holloway has not provided medical basis for his opinion that the Injury was a major contributing *cause* of AFib, his opinion is entitled to little, if any, weight.

Second, Dr. Holloway's testimony did not provide evidence that the Injury was a probable cause, not just a possible cause, of Claimant's AFib. (SR 2347-60). A claimant must establish causation "to a reasonable degree of medical probability, not just possibility." *Darling v. West River Masonry, Inc.*, 2010 SD 4, ¶ 12, 777 N.W.2d 363, 367. Dr. Holloway acknowledged that hyperthyroidism is certainly a precursor to AFib and that about 10% of people with hyperthyroidism develop AFib. (*Id.* at 2349, 2356). In contrast, while Dr. Holloway concluded that electrocution-induced AFib can occur, he provided no evidence on the strength of the association between electric shocks and AFib. (*Id.* at 2347-60). Without such evidence on the probably that an electric shock could cause AFib, Dr. Holloway's did not present evidence to show that the Injury, rather than Claimant's pre-existing hyperthyroidism, was a major contributing cause of Claimant's AFib.. (*See id.* at 2347–60).

In sum, the unrefuted evidence is that hyperthyroidism had a much, much higher probability of causing Claimant's AFib than electric shocks, such as the Injury. In fact, the probability is 100:1 in favor of hyperthyroidism based on Dr. Elkins's unrefuted testimony. *See Armstrong,* 2020 SD 1, ¶ 23, 938 N.W.2d at 431 (stating proof of causation must be established "to a reasonable degree of medical probability, not just possibility"). Additionally, Claimant has failed to present medical evidence on the causal relationship between the Injury and his AFib. Dr. Holloway did not provide medical evidence to support his opinion that the Injury was a major contributing cause of Claimant's hyperthyroidism. Instead, his opinion confused sequence with consequence. *See Rawls,* 2002 SD 130, ¶ 20, 653 N.W.2d, at 252. Claimant's medical records also cannot show that the Injury was a major contributing cause of Claimant's AFib. After the Injury, Claimant's EKGs were normal, and his heart suffered no structural damage that could account for his AFib. (*Id.* at 422, 2010–11). Further, by Claimant's own account, he consistently suffered an increase in palpitations when he stopped taking his thyroid medication. (*Id.* at 708, 1102, 1106, 1148). For all of these reasons, Claimant has not satisfied his burden of establishing entitlement to benefits. There is no medical reason to choose the cause of AFib that is 100 times less likely to be the cause of the Afib than hyperthyroidism.

B. The Department erred in finding that the Injury was a major contributing cause of Claimant's right-hand numbness.

i. De novo review applies.

The Circuit Court found that the Injury was a major contributing cause of Claimant's right-hand numbness relying on the deposition testimony of Dr. Holloway and its review of his medical records. (SR 2447–49). Therefore, *de novo* review applies. *See*

Peterson, 2012 SD 52, ¶ 19, 816 N.W.2d at 849 (holding *de novo* review applies when the Department's decision is based on its review of medical records and deposition testimony).

ii. The Court should find the Injury was not a major contributing cause of Claimant's hand numbness because Claimant failed to provide expert testimony on this claim.

Here, Claimant has failed to present expert testimony that the Injury was a major contributing cause of his current right-hand numbness. Therefore, the Department's decision must be reversed. Dr. Holloway opined the Injury was a major contributing cause of Claimant's hand numbness in September 2020. (*Id.* at 277). However, Claimant then testified that his right-hand symptoms significantly deteriorated in the two years since Dr. Holloway was deposed. (*Id.* at 371, 373, 386). And Dr. Holloway, unlike Dr. Elkins, did not examine or review Claimant's recent medical records to provide an opinion on whether the Injury could have caused the worsening of Claimant's symptoms. (*Id.* at 277). Additionally, Dr. Elkins provided unrefuted testimony that he did not know of any medical explanation as to why the Injury would cause delayed onset of Claimant's current symptoms. (*Id.* at 424). On this record, Claimant has failed to how that the Injury was a major contributing cause of his right-hand numbness and lack of sensation.

C. The Department erred in finding that Claimant was permanently and totally disabled under the odd-lot category.

Because Claimant has not shown the Injury was a major contributing cause of his AFib, he cannot show entitlement to permanent and total disability benefits. Nonetheless, Employer and Insurer address this claim below.

i. Clear Error review applies.

The question of entitlement to disability benefits is generally a question of fact subject to review under the clearly erroneous standard. *See Enger v. FMC*, 1997 SD 70, ¶ 22, 565 N.W.2d 78, 85 (applying the clearly erroneous standard in analyzing permanent total disability benefits). "A finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." *Fuoss v. Dahlke Fam. Ltd. P'ship*, 2023 SD 3, ¶ 22, 984 N.W.2d 693, 701. Under SDCL 1-26-36, this Court may reverse the Department's decision if the Department's "findings, inferences, conclusions, or decisions are . . . [m]ade upon unlawful procedure[,]" or [a]ffected by other error of law[.]" SDCL 1-26-36.

ii. Applying SDCL 62-4-53, Claimant was not permanently and totally disabled under the odd-lot category because he voluntarily resigned and because Employer had a suitable position for him.

SDCL 62-4-53 describes the criteria for obtaining permanent total disability benefits under the odd lot doctrine: "An employee is permanently totally disabled if the employee's physical condition, in combination with the employee's age, training and experience and the type of work available in the employee's community, cause the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income." SDCL 62-4-53. A claimant can establish a prima facie case of entitlement to odd-lot disability benefits by showing that: "(1) claimant is obviously unemployable due to his or her physical condition, coupled with his or her age, training, and experience" or by showing the "(2) unavailability of suitable employment by

showing that he or she has made reasonable efforts to find work and was unsuccessful." *Billman v. Clarke Mach., Inc.*, 2021 SD 18, ¶ 25, 956 N.W.2d 812, 820.

Once a *prima facie* case is established, "[t]he burden then shifts to the employer to show that some form of suitable work is regularly and continuously available to the employee in the community. SDCL 62-4-53. Then "[a]n employee shall introduce evidence of a reasonable, good faith work search effort unless the medical or vocational findings show such efforts would be futile. *The effort to seek employment is not reasonable if the employee places undue limitations on the kind of work the employee will accept or purposefully leaves the labor market.*" SDCL 62-4-53 (emphasis added).

Claimant argues that Audet's testimony was sufficient to support the Department's findings that he was obviously unemployable. (AB 36–41). However, Audet's testimony cannot support Claimant's request for permanent and total disability benefits because it runs counter to the evidence. In reaching his opinion, Audet failed to consider facts material to Claimant's employability. For instance, Audet failed to consider that Claimant continued to work for Employer without issue for almost a year after his Injury. (*Id.* at 2256–69). Audet also failed to consider unrefuted evidence that Employer would have accommodated Claimant's work restrictions and continued to employ Claimant had Claimant not retired. (*Id.* at 412, 2256–69). Carroll also refuted Audet's testimony that there were no jobs available for Claimant's restrictions. (*Id.* at 436–37, 1872–83, 2298–2300). With Claimant's excellent work history and management experience, Carroll testified that Claimant would have no difficulties obtaining a position with his current work restrictions and provided a list of many such open positions for which Claimant would be qualified. (*Id.*). For these reasons, Audet's testimony cannot

sustain Claimant's burden to show he was permanently and totally disabled. *See Johnson v. Lennox Sch. Dist. No. 41-4*, 2002 SD 89, ¶ 30, 649 N.W.2d 617, 625 (finding a board's decision arbitrary and capricious where it failed to consider important aspects of the problem and its decision ran counter to the evidence).

More importantly, even if Claimant had established a *prima facie* case of odd-lot disability, the Department's decision must be reversed. After a *prima facie* case of odd-lot disability is established, the burden shifts to the employer to "show that some form of suitable work is regularly and continuously available to the employee in the community." SDCL 62-4-53. Here, Employer and Insurer presented unrefuted testimony that Employer would rehire Claimant and accommodated his restrictions if he decided to return to work as well as presented evidence that Claimant was qualified for other jobs. *(Id.* at 412, 2298–2300). The Department erred by failing to consider this evidence as required by SDCL 62-4-53.[4] (*Id.* at 2449–54). Further, had the Department applied the burden shifting framework of SDCL 62-4-53, it would have determined Claimant was not entitled to benefits because he voluntarily left the labor market. *See* SDCL 62-4-53 (stating that a claimant has not met his or her burden to show "a reasonable, good faith work search effort. . . if the employee . . . purposefully leaves the labor market"). *See Kennedy v. Hubbard Milling Co* 465 N.W.2d 792, 794, 797 (S.D. 1991) (holding that a

[4] The Decision was not only an error in law, it also set a dangerous precedent. Under the Department's view, employees would be free to voluntarily leave full-time employment at their own discretion and secure permanent and total disability benefits without showing any change in their condition or reasonable effort to seek employment. Such a position is indefensible and expressly precluded by SDCL 62-4-53. *See* SDCL 62-4-53; *see also Whitney v. AGSCO Dakota*, 453 N.W.2d 847, 851 (S.D. 1990) (agreeing "[w]orkers' compensation should not become, by way of strained construction, unemployment insurance").

claimant was not totally and permanently disabled when he voluntarily retired and did not make a "reasonable effort to secure employment").

In short, Department erred in finding Claimant was permanently and totally disabled and in failing to apply burden-shifting framework set forth SDCL 62-4-53 in determining that Claimant was permanently and totally disabled. (SR 2449–54). As such, the Department's determination that Claimant is entitled to odd-lot disability benefits should be reversed.

CONCLUSION AND REQUEST FOR ORAL ARGUMENT

For the foregoing reasons, Employer and Insurer respectfully request that the Decision be reversed in full. Employer and Insurer also respectfully request oral argument.

Dated this 6th day of March, 2024

/s/ Charles A. Larson

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing Brief does not exceed the number of words permitted under SDCL 15-26A-66(b)(2), said brief containing 8,772 words, Times New Roman Font, 12 point, and 46,959 characters (no spaces).

Dated this 6th day of March, 2024.

/s/ Charles A. Larson

Charles A. Larson

CERTIFICATE OF SERVICE

I, Charles A. Larson, do hereby certify that I am a member of Boyce Law Firm, L.L.P., and that on the 6th day of March, 2024, the foregoing were filed and served upon:

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IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

Appeal No. 30494

MICHAEL ARNESON, *Claimant/Appellant,*

vs.

GR MANAGEMENT, LLC, d/b/a MINERAL PALACE CASINO,
Employer/Appellee, and

RISK ADMINISTRATION SERVICES, INC., *Insurer/Appellee.*

Appeal from the Sixth Judicial Circuit
Hughes County, South Dakota
The Honorable Christina Klinger
Circuit Court Judge

APPELLANT'S REPLY BRIEF

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES:

STATUTES:

I. PRELIMINARY STATEMENT

Employer and Insurer (E&I) argue the Department was erroneous in finding Arneson's workplace injury was a major contributing cause of his injuries and that he is permanently and totally disabled. Responses to E&I's arguments are set forth in the body of this Reply. The more significant issue, however, is that E&I contend *de novo* is the appropriate standard of review as to the Department's findings on causation of Arneson's injuries. As a result, E&I do not argue, let alone set forth any facts or explanation, as to how the Department's findings are clearly erroneous.

There were multiple pieces of evidence the Department considered that require an appellate court to review that evidence under the clearly erroneous standard versus the *de novo* standard. That evidence specifically includes findings related to the following: The Department's decision to reject the opinions of Dr. Elkins, provided live at hearing; the Department finding Arneson's testimony credible, that he experienced palpitations shortly after the shock event, which testimony was live at hearing; and the Department's consideration of, and findings related to, the live testimony of the parties' vocational experts and lay witnesses. E&I's failure to parse out this evidence separately, and consider it cumulatively, is fatal to its arguments and underscores the errors committed by the Circuit Court where in its Memorandum Opinion it

also failed to adhere to the appropriate standards of review when it reversed, in part, the Department's Decision.

II. DISCUSSION

A. THE DEPARTMENT WAS NOT CLEARLY ERRONEOUS WHEN IT FOUND THE INJURY WAS A MAJOR CONTRIBUTING CAUSE OF ARNESON DEVELOPING ATRIAL FIBRILLATION.

1. Standard of Review

E&I argue that this "Court reviews the Department's determination that the Injury was a major contributing cause of Claimant['s] AFib *de novo* [because] the Department's determination was based on Dr. Holloway's deposition testimony." (E/I Br. 21; citing SR 2556.) This is incorrect for several reasons. First, this Court has long held: "An agency's factual determinations will be overruled only if this Court finds them to be 'clearly erroneous' in light of the *entire evidence*." *Stang v. Meade Sch. Dist. 46-1*, 526 N.W.2d 496, 498 (S.D. 1995) (emphasis added). Second, the Department specifically stated at the outset of its Decision: "Based upon the evidence presented and live testimony at hearing, the following facts have been established by a preponderance of the evidence." (App. 12; *see also* FOF and COL (App. 38) wherein the Department listed all the live witnesses who testified.) Lastly, the Department conducted a detailed analysis of the opinions of Drs. Holloway, Brody, and Elkins before finding that Dr. Holloway's opinions were more persuasive. (App. 25-27.) As such, the Department's findings as it relates to the medical records and testimony

of Drs. Holloway and Brody are subject to *de novo* review. However, the Department's findings based on live testimony, specifically its decision to reject Dr. Elkins' live testimony at Hearing, are subject to clear error review. "[I]t is the function of the trier of fact to resolve conflicting testimony and evaluate credibility of witnesses to determine the comparative weight to be given to such testimony." *Kennedy v. Hubbard Milling Co.*, 465 N.W.2d 792, 795 (S.D. 1991).

2. The testimony of Drs. Brody and Elkins is not uncontroverted, unrefuted, or unrebutted.

E&I repeatedly assert that the testimony of its experts went uncontroverted, unrefuted, or unrebutted. Those statements are not accurate. Claimant clearly controverted the testimony of Drs. Brody and Elkins with the testimony of Dr. Holloway. Further, their opinions were controverted and impeached on multiple occasions based on the underlying facts of the case and information in medical articles cited in their reports. (*See* Appellant's Br. 19-24.) As such, E&I's arguments that the testimony of its experts went uncontroverted, unrefuted, or unrebutted is misleading and unfounded.

3. Dr. Elkins testified there are not enough cases to generate his 1 in 1,000 statistic.

It is evident E&I's primary argument as to why Claimant cannot prove causation is based on Dr. Elkins' testimony "that there is about a 1 in 1,000 medical probability that an electrical injury will induce AFib, while there is about a 1 in 10 probability hyperthyroidism induces

A[F]ib." (E/I Br. 24; *see also* E/I Br. 14, 18, 25, 27 (discussing the significance of the ratio disparity).) E&I also dispute that statistic was "pulled out of thin air" as alleged in Appellant's Brief. (E/I Br. 25; citing AB 31.) As discussed below, however, common sense and Dr. Elkins' own testimony shows there truly is no basis for that statistic.

First, the 1 in 1,000 statistic is not based on Dr. Elkins' personal knowledge because he has no medical expertise in any of Arneson's medical conditions that interrelate with the electric shock event which caused him to develop AFib. (*See* Appellant's Br. 22-24 (citing Dr. Elkins' testimony wherein he agreed he was not an expert, and had no special training, when it came to electricity, cardiology, atrial fibrillation, thyroid problems, or Graves' Disease).)

Second, the 1 in 1,000 statistic was never mentioned in any reports by Drs. Elkins or Brody. If it was such a critical piece of information, then why was it not discussed long before the Hearing.

Third, none of the medical articles marked as exhibits in the record indicate there is any legitimacy to the 1 in 1,000 statistic. (DI 1596-1619 (Exs. 10-12).)

Fourth, Dr. Elkins initially testified the report(s) he reviewed revealed there were a total of *5,000* patients involved: "But in the report I used, say, 1 out of 1,000, because when you add up the studies that I was reviewing, there was something in the neighborhood of, you know, 5,000 patients involved. And there was one case study, I believe -- and I

don't remember like how long the delay was." (HT 232:24-233:4.) However, Dr. Elkins arbitrarily decided to use an estimate of 1 in 1,000: "And there was one case study, I believe--and I don't remember like how long the delay was. I don't think it was even, you know, twelve days magnitude, but using a high estimate of 1 in 1,000 risk of developing atrial fibrillation from this type of injury, you know, 1 in 10 versus 1 in 1,000 risk is 100 times difference." (*Id.* at 233:4-8.)

Finally, and most importantly, Dr. Elkins testified at the Hearing on re-direct examination by counsel for E&I that there were not even enough cases to generate an estimate:

> It's still just the one -- it's still just the one case and what I said earlier was that, yeah, there's no incidence number. There's not you have a 1 in 10,000 risk, you have a 1 in 1,000 risk of developing atrial fibrillation. There just aren't enough cases to generate that estimate. So this is a case report of this happening and with different circumstances, the unconsciousness, the muscle damage and the spontaneous resolution.

(HT 280:20-281:3.)

Dr. Elkins is an occupational medicine doctor that provides testimony for insurance companies to make his living. (HT 258:4-7 (stating 99 percent of IMEs and records reviews he does are at the request of insurance companies).) He is not qualified to testify about this injury and the interrelationship of Arneson's unique medical conditions. In order to try to overcome this deficiency Dr. Elkins purportedly conflated the statistics from multiple different medical journal articles to come up with his 1 in 1,000 statistic. The Department was able to listen

to this testimony and the manner in which Dr. Elkins desperately tried to explain how he came up with this number. The Department did not find Dr. Elkins' testimony persuasive. In fact, in its Decision where it discussed Dr. Elkins' opinions and testimony the Department did not even reference his unfounded 1 in 1,000 statistic. *See Darling v. W. River Masonry, Inc.*, 2010 S.D. 4, ¶ 13, 777 N.W.2d 363, 367 ("Expert testimony is entitled to no more weight than the facts upon which it is predicated."); *Cf. Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146, 118 S. Ct. 512, 519, 139 L. Ed. 2d 508 (1997) ("[N]othing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert [and] [a] court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.")

Regardless, the Department's decision to disregard Dr. Elkins' opinion in favor of Dr. Holloway's opinions is not clearly erroneous. *See Wagaman v. Sioux Falls Const.*, 1998 S.D. 27, ¶ 18, 576 N.W.2d 237, 241 ("There was testimony from Dr. Cho that Wagaman's condition is work related. Department could rely on Dr. Cho's opinion, even though there was contradictory testimony. Therefore, Department's findings on this issue were not clearly erroneous, and we affirm."). Moreover, E&I do not even argue in their brief that the decision is clearly erroneous, let alone provide reasoning to support that argument.

4. Dr. Holloway clearly explained the basis and reasoning for his opinions.

E&I assert: "Claimant argues that Dr. Holloway's testimony was persuasive and sufficient to establish that the Injury was a major contributing cause of his AFib." (E/I Br. 25.) That statement is true, however, more importantly for purposes of this issue on appeal is that the *Department* found Dr. Holloway's testimony more persuasive and sufficient to establish that the Injury was a major contributing cause of Arneson's AFib. (CCI 2093; FOF 126.) As such, the correct inquiry is whether the Department's determination is "*clearly erroneous* in light of the *entire evidence*." *Stang*, 526 N.W.2d at 498 (emphasis added). E&I do not even allege the Department's findings were clearly erroneous let alone provide facts or reasoning therefore. Regardless, the arguments submitted to try to undercut Dr. Holloway's opinions are unfounded.

E&I allege: "Dr. Holloway presented no medical explanation or evidence for his conclusion that electric shock cause[d] AFib" and that "his opinion was based only on the fact that Claimant's AFib developed *after* the Injury." (E/I Br. 25.) That statement is not an accurate reflection of Dr. Holloway's testimony. Dr. Holloway considered all Arneson's medical records from Regional Health and Black Hills Orthopedic and Spine Center, the medical records summary identified in Exhibit 2, as well as his treatment of Arneson from the injury date through the deposition date. (CCI 2347; Holloway Dep. 6:5-7:12.) Dr. Holloway also conducted research into electrical injuries and AFib as

it relates to Arneson's case, having specifically used an online resource called UpToDate Textbooks of Cardiology. (CCI 2353; Holloway Dep. 29:3-10.) Dr. Holloway explained that the information he gathered that was helpful for expressing his opinions pertained to "the relationship between [ ] electrical injury and cardiac arrhythmias of burns and burn injuries, the relationship between thyroid conditions and cardiac arrhythmias, including atrial fibrillation, with respect to the frequency with which these rhythm disturbances are encountered in patients with overactive thyroids." (*Id.*, Holloway Dep. 29:18-24.)

When Arneson was discharged from the Emergency Department, he was provided a form entitled Electric Shock Injury. (CCI 1555; Ex. 4.) That form advises patients as follows:

> When electricity passes through the body, it can damage the skin and internal organs. A strong electric shock (*high voltage*) can harm the heart, muscles and brain.
>
> . . . .
>
> Most electric shock injuries that cause serious damage to the body are from a shock that is greater than 600 volts. However, just 50 volts of electricity may be enough to disrupt the heart's rhythm.

(*Id.*) The relevant signs and symptoms of this condition include: tingling and numbness; very bad pain; skin burns (*thermal burns*); chest pain; and very fast or irregular heartbeat (*palpitations*). (*Id.*) Dr. Holloway agreed that the symptoms on Exhibit 4 were also consistent with his

experience and how Arneson was presenting at the hospital. (CCI 2348; Holloway Dep. 10:11-21.)

Dr. Holloway explained how an electrical injury like Arneson experienced can cause damage to a person. (*Id.*; Holloway Dep. 9:21-10:10; *see also* 56:14-57:18 (explaining how lower voltage of electrical shocks can still disrupt circuitry of heart).) He also explained in detail how and why the work injury was a major contributing cause of the atrial fibrillation and its relationship to Arneson's thyroid. (CCI 2348-49; Holloway Dep. 10:22-13:5.)

E&I next argue: "Dr. Holloway's testimony did not provide evidence that the Injury was a probable cause, not [sic] just a possible cause, of Claimant's AFib." (E/I Br. 26.) This argument also fails for several reasons:

- First, this Court has long held: "There are no 'magic words' needed to express an expert's degree of medical certainty, and the test is only whether the expert's words demonstrate that he or she was expressing an expert medical opinion." *Orth v. Stoebner & Permann Const., Inc.*, 2006 S.D. 99, ¶ 44, 724 N.W.2d 586, 596.
- Second, in the medical records, Dr. Holloway clearly stated: "[H]e did not have fibrillation prior to the electrical shock and I think it is probable (greater than 50%) that, absent electrical shock, his thyroid condition would not have triggered atrial fibrillation."

Electrical injury. He and his wife asked me to render a judgment regarding how much of his current medical condition is related to the electrical shock. His neurologic symptoms, namely numbness of the right index, long and fourth finger, are clearly related to nerve damage from the electrical shock. It is possible that these will resolve over time, but it could take up to 2 years, and may not resolve at all. He does have some residual disability from this. The numbness interferes with his activities to the extent that he is clumsy when using his hand. He is right-handed. He ops things easily. This latter problem prior to the injury. Paroxysmal atrial fibrillation is, in my judgment, also related o his electrical shock injury. It caused electrical instability of the heart, which can persist for an extended time afterwards. Unfortunately, once a person has developed paroxysmal atrial fibrillation from a triggering cause, they are

04/24/2019 - Office Visit in RH Medical Clinic Internal Medicine (continued)

All Clinical Notes (continued)

still prone to have episodes of this at a later date, long after the injury. His hyperthyroidism was not caused by the electrical injury. However, this condition was aggravated by electrical injury, to the extent that the latter was responsible for the development of paroxysmal atrial fibrillation. Although atrial fibrillation can be seen in patients who are hyperthyroid, due to thyroid overactivity, he did not have fibrillation prior to the electrical shock and I think it is probable (greater than 50%) that, absent electrical shock, his thyroid condition would not have triggered atrial fibrillation.

(CCI 1105-06.)

- Third, at the outset of his deposition, Dr. Holloway agreed his opinions were based on the "a major contributing cause" standard:

> Q And in this case Mr. Arneson needs to establish to a reasonable degree of medical probability that his work-related activities are a, not the, major contributing cause of his injury and condition, a cause which cannot be exceeded as a major contributing cause.
>
> Can we agree that your opinions today are based on this standard?
>
> A Yes.

(CCI 2348; Holloway Dep. 7:13-21; *see also* CCI 2348-49; Holloway Dep. 10:25-13:5).)

Dr. Holloway clearly stated his opinions were based on probabilities (greater than 50%) and not mere possibilities. Again, E&I base all of their arguments on the assumption Dr. Elkins' 1 in 1,000 statistic is accurate and do not even discuss why the Department was clearly erroneous in accepting Dr. Holloway's opinions over those of E&I's doctors.

B. THE DEPARTMENT WAS NOT CLEARLY ERRONEOUS WHEN IT FOUND THE INJURY WAS A MAJOR CONTRIBUTING CAUSE OF ARNESON DEVELOPING RIGHT-HAND NUMBNESS.

1. Standard of Review

E&I again argue that *de novo* is the only standard of review that applies to this issue. (E/I Br. 27.) Claimant disagrees and submits that the findings related to the testimony of Drs. Holloway and Brody, along with the medical records, are subject to *de novo* review, but the findings related to the live testimony of Dr. Elkins and the other live witness is the clearly erroneous standard. In reviewing factual findings of an administrative decision, "[t]he question is not whether there is substantial evidence contrary to the findings, but whether there is substantial evidence to support them." *Abild v. Gateway 2000, Inc.*, 1996 S.D. 50, ¶ 6, 547 N.W.2d 556, 558. "The issue we must determine is whether the record contains substantial evidence to support the agency's determination." *Helms v. Lynn's, Inc.*, 1996 S.D. 8, ¶ 10, 542 N.W.2d 764, 766 (citation omitted). "If after careful review of the entire record we are definitely and firmly convinced a mistake has been committed, only then will we reverse." *Reede v. State Dep't of Transp.*, 2000 S.D. 157, ¶ 9, 620 N.W.2d 372, 374 (citations and quotations omitted).

2. The medical records and experts confirm the work injury is a major contributing cause of Arneson's right hand numbness and limitations.

E&I state: "Claimant has failed to present expert testimony that the Injury was a major contributing cause of his current-right hand numbness." (E/I Br. 28.) Again, this argument is false. The medical records clearly document that the electrical shock was the cause of his hand symptoms, Arneson presented evidence by Dr. Holloway that the numbness was from the electrical shock, and Dr. Brody agreed the shock caused Arneson's burns and numbness.

a) The Department and Circuit Court agreed the numbness Arneson experiences in his right hand was caused by the work injury.

The Department was persuaded more by the testimony of Dr. Holloway than the other experts:

> The Department is persuaded by Dr. Holloway's testimony that the electrical shock injury is a major contributing cause of Arneson's ongoing issues with numbness and sensation in his right hand. It appears that the electrical shock caused nerve damage that has only partially healed and as of the time of the hearing, he was still experiencing significant issues with his hand. Additionally, the medical record shows that Arneson has consistently complained of finger numbness and paresthesia since the injury. The electrical injury is a major contributing cause of Arneson's right-hand issues.

(App. 28-29.) The Circuit Court agreed. (App. 8-9.) As explained below, "the record contains substantial evidence to support the agency's determination." E&I have not presented *any* evidence to meet their burden of proving the Department was clearly erroneous when it ruled in Arneson's favor on this issue.

b) The medical records document Arneson's right hand complaints.

Arneson consistently complained of right-hand symptoms from the day he was shocked and went to the emergency department as documented in the medical records and medical summary:

- 7/18/2018: Exam: Report intact soft tissue sensation on the flexor and extensor surfaces of the digits of the right hand, right hand and the right upper extremity. The patient has a 2.5 cm area of darkened discoloration on the medial aspect of the right index fingertip he also has 6 cm pale discoloration with blister formation near the nail plate of the ring finger and also has 6 cm pale discoloration with darkened discoloration on medial nailbed with linear distribution extending on the dorsum of the digit of the right middle finger. Pt. also has 4 cm linear discoloration on the dorsum of the right pinky. There is minor edema at the location of the electrical injuries there is no edema of the hand wrist or forearm. (CCI 518-19.)

- 7/20/2018: He stated that his burns were not worsening and his chief complaint was finger paresthesia. (CCI 540.)

- 7/20/2018: Mr. Arneson . . . sustained an electrical shock. He later developed some blisters on his fingers and was seen in the ER [ ]. . . . He reports some slight numbness in his fingertips. (CCI 1325.)

- 9/26/2018: He is here for follow up of an electrical shock injury. His right 3 middle fingers are still numb. (CCI 774.)

- 1/08/2019: Patient is here for follow up of electric shock injury to right hand and paroxysmal atrial fibrillation, thought to have been triggered by the electric shock injury. He still has numbness of this right second, third and fourth fingers. Initially, they were black and later blistered. Skin wounds have healed, but they are still numb. (CCI 849.)

- 4/20/2019: Electrical injury: His neurologic symptoms, namely numbness of the right index, long and fourth finger, are clearly related to nerve damage from the electrical shock. It is possible that these will resolve over time, but it could take up to 2 years, and may not resolve at all. He does have some residual disability from this. The numbness interferes with his activities to the extent

that he is clumsy when using his hand. He is right-handed. He drops things easily." (CCI 1105.)

- 8/01/2019: Patient is here for Worker's Compensation visit and associated issues. Does have ongoing numbness in the fingertips of his index long, and fourth finger. He cannot pick up a dime with his right fingers, because he cannot feel well enough to do so.

. . . .

- Electrical shock of hand. Continues to exhibit right median nerve neuropathy and right ulnar nerve neuropathy. . . .Therefore, I think the electric shock caused damage to both nerves. Either way, the symptoms were not present prior to the injury." (CCI 1125-26.)

As the records plainly show, Arneson was consistently complaining about numbness and loss of sensation in the fingers of his right hand and Dr. Holloway attributed the cause of those symptoms to the work injury.

It is difficult to even understand how E&I can represent in their brief that "Claimant has failed to present expert testimony that the Injury was a major contributing cause of his current-right hand numbness." In addition to the medical records, Dr. Holloway gave a very detailed discussion about Arneson's hand and nerve injuries that he relates to the work injury. (CCI 2349-50; Holloway Dep. 13:7-15:4.)

Moreover, E&I's own expert, Dr. Brody, agreed that the electricity went in Claimant's right hand and out his left foot and was the cause of his finger numbness:

> Q And then the electricity went into his right hand and out his left foot, causing burns and numbness in his fingers. Would you agree with me that the work injury was the cause of the burns?

A Absolutely.

Q Would you agree with me that the work injury was the cause of the numbness in his fingers that he was experiencing?

A Yes.

(CCI 2412; Brody Dep. 27:19-28:2.) Dr. Brody also agreed that when Arneson presented to the emergency department on July 30 he was experiencing tingling and numbness in his fingers, very bad pain, skin burns, and a fast and irregular heart beat—as set forth on Ex. 4. (CCI 2412; Brody Dep. 28:3-29:3.) In fact, even Dr. Elkins admitted he was "not disputing that [Arneson's] chief complaint [to Black Hills Orthopedic] was finger paresthesias or tingling and he reports some slight numbness in his fingertips" after the electrical shock. (HT 263:4-265:9.)

C. THE DEPARTMENT WAS NOT CLEARLY ERRONEOUS WHEN IT FOUND THAT ARNESON WAS PERMANENTLY AND TOTALLY DISABLED.

1. Standard of Review

"Whether the claimant made a prima facie case that he belongs in the odd lot total disability category is a question of fact." *Lends His Horse v. Myrl Roy's Paving, Inc.*, 2000 S.D. 146, ¶ 9, 619 N.W.2d 516, 519 (quotations and citation omitted). "The test to determine whether a prima facie case has been established is whether there are facts in evidence which if unanswered would justify persons of ordinary reason and fairness in affirming the question which the plaintiff is bound to maintain." *Billman v. Clarke Mach., Inc.*, 2021 S.D. 18, ¶ 29, 956 N.W.2d 812, 820–21 (internal quotations and citations omitted). "This Court will

not overturn the Department's determination that a claimant met his prima facie burden showing that he belongs in the odd-lot total disability category, unless such a finding is clearly erroneous." *Stang*, 526 N.W.2d at 498 (citations omitted). E&I agree that review of this issue is based on the clearly erroneous standard. (E/I Br. 29.)

2. E&I have not presented credible arguments as to how the Department was clearly erroneous in finding Claimant made a prima facie case of entitlement to odd-lot disability benefits.

a. E&I were not precluded from offering evidence there was employment for Claimant.

E&I also argue the Department erred, and must be reversed, because it did not afford them their statutory right to rebut Claimant's showing that he is obviously unemployable. (E/I Br. 31.) Contrary to that argument, the Department did not restrict E&I from presenting all of the evidence desired on this issue, and even cited SDCL 62-4-53, which sets forth the framework to follow when analyzing permanent total disability claims. (App. 29-30; *cf. Kristi Helen Thompson, Claimant*, No. HF No. 29, 2014/15, 2017 WL 7511235, at *12 (S.D. Dept. Lab. Feb. 24, 2017) (wherein Judge Faw previously applied the burden-shifting analysis once a claimant has made a prima facie case that she is obviously unemployable).) In fact, the Department specifically set forth E&I's arguments as to why Arneson was not obviously unemployable and even referenced testimony from their vocational expert Jim Carroll. (App. 30-33.) However, the Department rejected those arguments, as well as

the testimony of Carroll, and instead agreed with the opinions and testimony of Claimant's vocational expert, Tom Audet, who opined that with Arneson's age and restrictions it was futile for him to seek a job and retraining was not feasible. (App. 32-33.)

Nevertheless, even if the Court finds that the Department did not adequately address E&I's employability argument, any such error was harmless. *See Enger v. FMC*, 1997 S.D. 70, ¶ 16, 565 N.W.2d 79, 84; quoting *Jennings v. Jennings*, 309 N.W.2d 809, 812 (S.D. 1981) ("trial court's use of clear and convincing standard in fraud case instead of correct preponderance standard was harmless error when there was no evidence of fraud to meet either standard"). As set forth below, the E&I's expert did not disclose Arneson's work restrictions when reaching out to prospective employers, and due to his injury, he was no longer able to work at his current employment.

b. Tom Audet's opinion were based on all relevant evidence.

E&I contend vocational expert Tom Audet's testimony was insufficient to support the Department's finding because "Audet failed to consider that Claimant continued to work for Employer without issue for almost a year after his Injury." (E/I Br. 30.) Again, this argument is incorrect. Audet specifically noted in his Supplemental Report that he talked to Arneson about the reasons why he quit work on June 1, 2019 and how "he just didn't feel that he was capable of doing the work."

(*See* DI 1650, Audet Supp. Rpt., Apr. 20, 2020.) Moreover, Audet testified at the Hearing he was aware of, and considered, this fact:

> Q Are you aware that Mr. Arneson worked for ten months after his injury at Mineral Palace?
>
> A Yes.

(CCI 2265; HT 162:1-3.)

E&I next argue that "Audet also failed to consider *unrefuted* evidence that Employer would have accommodated Claimant's work restrictions and continued to employ Claimant had Claimant not retired." (E/I Br. 30 (emphasis added).) Again, this fact was refuted. When E&I answered interrogatories asking if there were any jobs available at the Mineral Palace, none were listed or offered to Arneson. (DI 1732-33; Ex. 37 pp. 4-5.) Diana Prado confirmed this at hearing:

> Q Okay. But in this discovery request to know if there are any jobs available for my client and none were provided to him?
>
> A No. It sounds like none were provided.

(HT 210:14-17.) Moreover, as of the date of the hearing, nobody from the Mineral Palace had contacted Arneson and offered him his old job back, or any job for that matter, with or without restrictions. (HT 190:24-191:11 (Hall); 210:18-211:21 (Prado).)

c. Carroll never spoke with any prospective employers and did not identify all Arneson's restrictions.

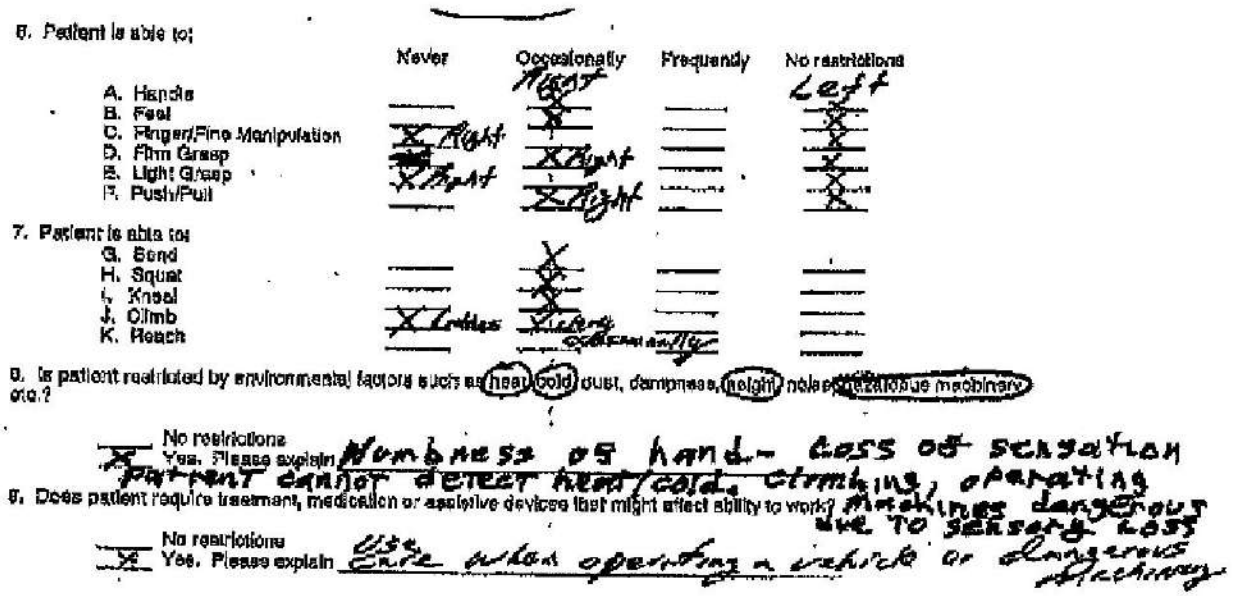
E&I also argue that their vocational expert, James Carroll, testified there were jobs that Arneson could perform with his current work

restrictions. (E/I Br. 30.) However, the Department considered Carroll's live testimony and accepted Audet's testimony and opinions as more persuasive. (App. 31-34.) E&I have not presented any facts or arguments as to why the Department was "clearly erroneous" for making that determination other than merely stating there was a disagreement of expert opinions. Notably, there is usually conflicting vocational expert opinions in every contested worker's compensation case. The mere existence of conflicting testimony cannot, in and of itself, automatically constitute clear error.

E&I failed to meet their burden in showing the Department was clearly erroneous for several reasons, which also constitute substantial evidence supporting the Department's decision. First, Carroll never personally spoke with potential employers to see if they would accommodate Arneson's restrictions and did not include all of Arneson's restrictions when considering what jobs were available. (HT 307:5-8.) As such, Carroll could not testify to what was said to these potential employers, what restrictions they were told, nor could he testify to the employers' response once they were provided Arneson's restrictions. This deficiency should be enough to find E&I have not met their burden of proof in identifying jobs that would actually hire Arneson.

Secondly, Carroll testified on direct examination that he only considered Arneson's restrictions on Exhibit 6 as they related to his right hand. (HT 296:6-17; *see also* 299:5-19.) Even then, Carroll did not relay

all Arneson's limitations regarding his ability to use his right hand. Carroll simply advised these prospective employers Arneson had "limited use of right hand." (HT 308:18-23.) That description is a far cry from Arneson's stated restrictions, which are supported by both Dr. Holloway and Dr. Elkins, and listed on Exhibit 6:


6. Patient is able to:

	Never	Occasionally	Frequently	No restrictions
A. Handle		Right		Left
B. Feel		X		X
C. Finger/Fine Manipulation	X Right			X
D. Firm Grasp	X Right	X Right		X
E. Light Grasp		X Right		
F. Push/Pull				X

7. Patient is able to:

G. Bend		X		
H. Squat		X		
I. Kneel		X		
J. Climb	X Ladder	X Heavy occasionally		
K. Reach				

8. Is patient restricted by environmental factors such as heat, cold, dust, dampness, height, noise, vibration, machinery etc.?

X No restrictions
___ Yes. Please explain Numbness of hand - loss of sensation patient cannot detect heat/cold. climbing, operating machines dangerous due to sensory loss

9. Does patient require treatment, medication or assistive devices that might affect ability to work?

___ No restrictions
X Yes. Please explain use when operating a vehicle or dangerous machinery

(DI 1576.)

Carroll explained he did not take into account the restrictions on Exhibit 6 regarding Arneson's ability to walk, sit, drive, and the amount of weight he could lift at various frequency, because it purportedly was not supported by any of the medical professionals.[1] (HT 302:2-9.) Carroll then explained he discounted Arneson's symptoms and restrictions from his AFib because the doctors in this matter did not say those restrictions applied to Arneson. (HT 302:18-24.) Carroll later tried

[1] Carroll also testified it was his understanding Dr. Elkins had not applied any restrictions either. (HT 299:20-22.)

to qualify his reasoning as to why he did not consider Arneson's symptoms from AFib was "because you cannot quantify atrial fibrillation." (HT 303:7-15.) Regardless of Carroll's reasoning, and as cited above, Dr. Holloway certainly endorsed the restrictions relating to Arneson's AFib. (CCI 2351-52; Holloway Dep. 22:7-25:24; 52:5-6.) More importantly, Dr. Elkins also endorsed all the restrictions in Exhibit 6 when he testified at the Hearing. (HT 274:23-275:4.) It is evident that neither Carroll, nor co-worker Katie Medema, disclosed to the prospective employers *all* Arneson's limitations. (*See* HT 312:5-13 (Carroll admitting Katie Medema would not have talked about fatigue or AFib issues with employers either); *see Eite*, 2007 S.D. 95, ¶ 28, 739 N.W.2d at 273 ("An expert's listing of jobs that focuses on a claimant's capabilities to the exclusion of his limitations is insufficient as a matter of law."). The reasoning in *Eite* applies to Arneson's case and the Department's determination that Audet's opinions were more persuasive than Carroll's is not clearly erroneous.

III. CONCLUSION

Arneson respectfully requests that this Court enter an Opinion reversing the Circuit Court and affirming the Decision of the Department of Labor finding the electrical shock was a major contributing cause of Arneson's injuries and that he is permanently and totally disabled under the odd-lot doctrine.

Dated this 5th day of April, 2024.

BEARDSLEY, JENSEN & LEE,
PROF. L.L.C.

By: /s/ Brad J. Lee

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CERTIFICATE OF COMPLIANCE

Pursuant to SDCL 15-26A-66(b)(4), I certify that Appellant's Reply Brief complies with the type volume limitation provided for in the South Dakota Codified Laws. This Brief contains 4,980 words and 25,978 characters. I have relied on the word and character count of our processing system used to prepare this Brief. The original Appellant's Reply Brief and all copies are in compliance with this rule.

Dated this 5th day of April, 2024.

By: /s/ Brad J. Lee

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on April 5, 2024, he electronically filed a copy of *Appellant's Reply Brief* with the South Dakota Supreme Court through the Odyssey system and that one bound copy of the same was filed by serving by mail upon:

Ms. Shirley A. Jameson-Fergel
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A true and correct copy of *Appellant's Reply Brief* was also provided by electronic means through the Odyssey system to:

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/s/ Brad J. Lee
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