THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ADMINISTRATIVE LAW COURT

Deborah Brooks Durden, Administrative Law Judge

Docket No. 16-ALJ-30-0293-AP

L'Tonya Scott, ...Appellant,

v.

South Carolina Public Employee Benefit Authority,
Employee Insurance Program,..... Respondent.

SUPPLEMENTAL RECORD ON APPEAL

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SUPPLEMENTAL RECORD ON APPEAL INDEX

Other Materials and Documents

Medical Records Order Confirmation 253

State of South Carolina Long Term Disability Insurance Employer's Statement 254-55

Social Security Disability Questionnaire.....256-59

Dr. Joan Wynn Taylor June 26, 2013 Office Visit Note.....260-63

Medical Record Request Complete Form.....264

Order Complete

Your Weborder Transaction ID is: 2051897

Please be sure to write this number on the authorization form when sending to ReleasePoint, or print this page and fax it along with the autho to:

626-768-7064

Name: SCOTT, LTONYA L
DOB: [redacted]
SSN: [redacted]
Policy Num: VQ6781
Source Code: STS

Provider 1: Andrew D Safter
Address: 615 Wesley Dr.
CHARLESTON, SC 29407
Phone: 843-225-5575
Record Range: Obtain records from 01/01/2012 to Present

Provider 2: Dr. Charles S Greenberg
Address: 171 Ashley Ave
Charleston, SC 29425
Phone: 843-792-1414
Record Range: Obtain records from 01/01/2012 to Present

[redacted]

Standard Insurance Company
Employee Benefits Department 800.628.9696 Tel 800.437.0961 Fax
PO Box 2800 Portland OR 97208-2800

State of South Carolina
Long Term Disability Benefits
Employer's Statement

Please type or print. Form may be returned for unanswered questions.
NOTE: Standard Insurance Company is acting only in an administrative capacity for the Basic LTD Plan.

1. EMPLOYEE

Full Name: Tonya L. Scott Social Security No.: [redacted]
Address: 3716 Hwy 17 North City: Mt. Pleasant State: SC Zip Code: 29464
Phone No.: [redacted] Birthdate: [redacted]

2. INFORMATION

Job Title: Terminal Clerk Date Employed: 5/18/2001
(Please attach a copy of position description.)
Employee's work location (agency/institution): SC State Ports Authority Group No.: V08000
Employee's coverage effective date: ☑ State Basic LTD 1/1/2011
☑ Supplemental LTD 1/1/2011 ☑ 90-day ☐ 180-day Benefit Waiting Period
Is employee currently insured with another carrier for disability coverage? ☐ Yes ☑ No Carrier: N/A
Did employee receive a certificate of coverage for each appropriate plan? ☐ Yes ☐ No ☑ Don't Know (Please forward Certificate of Coverage for State Basic LTD plan for covered employee when filing disability claim.)
Last day of work before disability commenced: 5/9/12
Date employee returned to work after disability ended: has not returned to work
Is medical condition due to employment? ☐ Yes ☑ No ☐ Undetermined
Workers' Compensation claim? ☐ Yes ☑ No Carrier Name: —
Claim No.: — Address: —
Have you considered allowing the employee to work in another occupation, or to modify and/or alter the job duties of the current occupation?
☐ Yes ☑ No Please explain: unable to work per doctor's orders
On FMLA? ☑ Yes ☐ No Effective date: 5/10/12 through: 8/1/12
Is employee terminated? ☐ Yes ☑ No Effective: — Reason: —
Is employment scheduled for termination? ☐ Yes ☑ No Effective: — Reason: —
Hours worked per week before disability commenced: 40.00 hrs/wk
Date sick leave benefits paid through: 5/17/12 Salary continuation from: 5/10/12 through: 5/17/12
Is Claimant on LWOP? ☑ Yes ☐ No Effective: 5/18/12 through: still on LWOP

3. SALARY *(Earnings as of last day worked before disability commenced)*

Regularly paid 40.00 hours per week, excluding overtime.
Please check ONE:
☐ Basic Yearly Earnings $ —
☐ Basic Monthly Earnings $ — for — months per year
☑ Basic Hourly Earnings $ 17.80 for 12 months per year OR — days per year
☐ Basic Contract Earnings $ — length of contract: —
☐ Commissions (Please attach list of commissions paid for the period specified in your Group Policy)
☐ Shift Differential ☐ Bonuses
Date of last increase: 11/21/11 Earnings prior to increase: $ 17.35 /hr.
Yearly employment schedule, indicate: ☑ 12-month period ☐ Other (i.e. contract days, 9 mos., etc.): —

Standard Insurance Company
Employee Benefits Department 800.628.9696 Tel 800.487.0961 Fax
PO Box 2800 Portland OR 97208-2800

State of South Carolina
Long Term Disability Benefits
Employer's Statement

4. DEDUCTIBLE INCOME

Is employee eligible for or now receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Receiving Don't Know	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Optional Retirement Plan Acct. No.: ____ ☐ TIAA/CREF or ☐ Other: ____	☐	☑	☐	☐	☐				
b. PORS	☐	☑	☐	☐	☐				
c. SCRS	☑	☐	☐	☐	☑				
d. GARS	☐	☑	☐	☐	☐				
e. JRS	☐	☑	☐	☐	☐				
f. Social Security	☐	☑	☐	☐	☑				
g. Workers' Compensation Claim No.: ____	☐	☑	☐	☐	☐				
h. Leave Pool or Shared Leave	☐	☑	☐	☐	☐				
i. Other: ____ (e.g. short-term disability insurance, another long-term disability plan, unemployment or union benefits, etc.)	☐	☑	☐	☐	☑				

If this employee does not belong to SCRS, please provide our office with the name and telephone number of the contact person for this employee's retirement plan.

Person to contact: N/A Telephone: (____) ____

5. TAX INFORMATION

Is this employee subject to Social Security taxes? ☑ Yes ☐ No

If yes, what are the employee's year-to-date Social Security wages? 17,302.77

If the employee has Supplemental LTD Coverage:

What percentage of the Supplemental LTD premium does the employer pay? 0 %

the employee pay? 100 %

Are Supplemental LTD premiums paid with pre-tax dollars under a Section 125 or cafeteria plan? ☐ Yes ☑ No

Has this Supplemental LTD contribution percentage changed within the last three years? ☐ Yes ☑ No

Employer's Federal Tax ID Number: 57-6000923

6. ATTACHMENTS *(Please check and attach copies of the following)*

- ☑ Employee's current W-4 form, include withholding allowances
- ☑ The 2 most current Notice of Election forms with signed authorization that verifies Health Plan enrollment for at least 1 year or for the duration of coverage, whichever is less
- ☑ Supplemental LTD Enrollment form(s), including refusal of coverage if applicable
- ☑ Job class specification and position description
- ☑ Employment Application or Resume
- ☐ Deductible Income Documents (Social Security, Workers' Compensation, SCRS, etc.) if available

7. EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: SC State Ports Authority Phone No.: 843.577.8781 Policy No.: ____

Address: 176 Concord St. City: Charleston State: SC Zip Code: 29401

Acknowledgment

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the applicable fraud notice on page 16 of this form.

Signature: [signature] Date: 8/16/12

Prepared by: Terri Haynes Title: ____

Phone No.: (843) 577-8781 Fax No.: (843) 577-8128

SOCIAL SECURITY DISABILITY QUESTIONNAIRE

Patient: L'Tonya Scott

Social Security Number: [redacted] Date of Birth: [redacted]

1. Diagnosis (with onset): Sickle cell disease & beta thalassemia, onset at birth (congenital)

2. What medical findings support your assessment? (For example, x-rays, MRI's, lab tests, orthopedic exam/test) hemoglobin electrophoresis

3. In your opinion is the patient's ability to walk, stand or sit affected by any impairment? Yes ☒ No ☐

4. During an eight-hour work day, how many hours can the patient tolerate:

		Total (8 hours)	Uninterrupted
WALKING:	a. Less than one hour	☐	☐
	b. One to two hours	☐	☐
	c. Two to four hours	☒	☐
	d. Four to six hours	☐	☐
	e. Six to eight hours	☐	☐
STANDING:	a. Less than one hour	☐	☐
	b. One to two hours	☒	☐
	c. Two to four hours	☐	☐
	d. Four to six hours	☐	☐
	e. Six to eight hours	☐	☐

		Total (8 hours)	Uninterrupted
SITTING:	a. Less than one hour	☐	☐
	b. One to two hours	☐	☐
	c. Two to four hours	☐	☐
	d. Four to six hours	☒	☐
	e. Six to eight hours	☐	☐

5. Is the patient able to work eight-hours a day, five days per week, for the duration longer than three months? Yes ☐ No ☒

Please give reasons for your answer:
chronic intermittent pain that is worsened by various environmental stimuli (ex stress, weather changes)

6. Is the patient's ability to lift or carry objects affected? Yes ☒ No ☐

Which category below best describes the amount of weight the patient can lift and/or carry and how often?

Less than 5 pounds	Frequently ☐	Occasionally ☐ Never ☐
5-10 pounds	Frequently ☐	Occasionally ☒ Never ☐
10-20 pounds	Frequently ☐	Occasionally ☐ Never ☐
20-50 pounds	Frequently ☐	Occasionally ☐ Never ☐
Over 50 pounds	Frequently ☐	Occasionally ☐ Never ☐

7. Is the patient restricted in climbing stairs or ladders? Yes ☒ No ☐

8. Is the patient restricted in bending? Yes ☐ No ☒

9. Does the patient require any rest periods during the day? Yes ☒ No ☐
If yes,
Number of rest Periods 6-8 (varies) for 20 min - 1 hour minutes per rest period

10. Please list any emotional problem or mental dysfunction experienced by the patient:
mild depression, insomnia

11. List medication prescribed and side effects experienced by the patient:

Rx: Hydrocodone/ 5-600 mg PO every 4 hours PRN Side Effects Sedation

Rx: Trazodone Side Effects Sedation

Rx: Lisinopril Side Effects Low blood pressure

Rx: Ambien Side Effects sedation/somnolence/d

Rx: _____ Side Effects _____

12. Does the patient experience pain due to his/her impairment?

None ☐ mild ☐ moderate ☐ severe ☒ extreme ☐

Symptoms associated with pain – Check all that apply:

☒ Pervasive loss of interest most activities ☐ Sleep disturbance

☐ Appetite disturbance with change in weight ☒ Crying spells

☐ Psychomotor agitation or retardation ☒ Decreased energy

☒ Feelings of guilt or worthlessness ☐ Thoughts of suicide

☒ Difficulty concentrating or thinking

13. Do you feel the patient's reports of pain are credible? Yes ☒ No ☐

14. a) Do you expect improvement or continuing improvement in the patient's condition? Yes ☐ No ☒

If yes, please describe your prognosis. For example, when do you expect improvement or which procedure is needed for possible improvement:

_____

_____

_____

b) Has the patient been, or do your expect the patient to be disabled for twelve months in a row? Yes ☒ No ☐

15. Which category most appropriately applies to the patient? Please check one box:

☐ Less than Full Range of Sedentary

If any of the following exist, please check less than full range of sedentary:

Restrictions on the use of one or both hands.
Doesn't have full use of upper extremities & restricted to seated position
Use of one leg only and uses assisted ambulation device (cane/walker)
Inability to perform the minimal standing/walking required by sedentary work, or inability to do prolonged sitting.
Cannot sit at least 6 hours in an 8hour day, despite alternating sitting and standing

☒ Sedentary work at less than 40 hours total per day

Sitting at least 6 hours/8 hour day.
Certain amount of walking and standing.
Frequent light lifting and/or carrying of small items.
Maximum lifting of up to 10 pounds.

☐ Sedentary

Sitting at least 6 hours/8 hour day.
Certain amount of walking and standing.
Frequent light lifting and/or carrying of small items.
Maximum lifting of up to 10 pounds.

☐ Narrow Range of Light Work (If any factor exists)

Restriction to standing and/or walking less than 6 hours in an 8 hour day
Restricted to work in a seated position with no lifting restrictions
Loss of use of one upper extremity.
Significant loss of use of 2 upper extremities.
Inability to lift at least 15 pounds occasionally and 10 pounds frequently

☐ Light (Full or Wide Range):

Standing and/or walking at least 6 hours/8 hour day:
Sitting about 2 hours/8 hour day using hands/feet for pushing & pulling
Lifting 20 pounds maximum with frequent lifting of up to 10 pounds

Physician's Signature Date Signed: 11/4/13

67 President St. Charleston, SC 29425
Facility Address or Telephone Number

Please return to Joye Law Firm via facsimile (843) 725-2343

RECEIVED
NOV 1 1 2013
SIC BENEFITS DEPT.

Joan Wynn Taylor, M.D.
General Medicine Practice

Visit Note - Office Visit

Provider: Joan Wynn Taylor, MD
Encounter Date: Jun 26, 2013

Patient: Scott, L'tonya (2444)
Gender: Female DOB: [redacted] Age: 34 year 2 month
Race: African American
Address: 2716 HWY 17 NORTH, Mount Pleasant SC 29466

Complaint:
Ms. Scott, 34 year 2 month old patient is here for regular follow-up visit. Patient complains of dizziness. It was noted 3 weeks ago and was sudden in onset. She reports symptoms as moderate. It is associated with imbalance, lightheadedness and weakness. No aggravating factors identified by the patient. No relieving factors are identified by the patient. Due to her illness, she has been worried. No other illnesses. Patient has had no similar problem in the past. No prior consultations were done. She has not tried any form of treatment for the condition.

Current Medication:
1 Lisinopril 20 Mg Tablet SIG: Take 1 daily
2 Amoxicillin 500 Mg Capsule SIG: Take 1 capsule(s) by mouth three times a day x 5
3 Medrol 4 Mg Dosepak SIG: Take as directed
4 Restoril 15 Mg Capsule SIG: Take 1-2 tablet(s) by mouth at bedtime as needed
5 Amlodipine Besylate 10 Mg Tab (Other MD) SIG: Take 1 daily
6 Folic Acid 1 Mg Tablet (Other MD) SIG: Take 1 daily

ROS:
Unremarkable with the exception of the chief complaint.

Medical History:
Hypertension.
Blood transfusion. Transfusion was done on 05-09-12.
Sickle cell anemia.

Social History:

Patient has never smoked or used tobacco products.
She denies alcohol use.
She denies recreational drug use.
Patient is single.
Patient lives with father, mother and her 2 sisters.
Patient denies being sexually active.
The patient is currently unemployed for one month.
The patient completed high school (12).
Patient exercises in the form of walking (daily).
Patient denies any interests in hobbies or other activities.
She follows a non restricted diet. The patient has 3 meals/day.
The patient is able to bathe herself, clean the house, be continent of bladder, be continent of bowel, converse meaningfully, cook, dress herself, drive, feed herself, find her way home, live independently, recognize familiar faces, remember the current date, remember her own name and remember where she lives but not ride public transportation.
She denies drinking caffeinated coffee. She denies drinking caffeinated soda. She denies drinking caffeinated tea.
The patient has not been exposed to any environmental factors which may affect her medical condition.
Patient has no recent travel.

Vital Signs:

Weight:	166 lbs 3 oz
Height:	5' 4"
BMI:	28.51
Temperature:	98.3 F
BP:	112/70
Pulse:	88
Respiration:	12

Allergy:
Gatifloxacin

Examination:
General Appearance: Patient is a 34 year 2 month old female who appears pleasant, in no apparent distress, her given age, well developed, well nourished and with good attention to hygiene and body habitus. Oriented to person, place and time. Mood and affect normal and appropriate to the situation.
Skin: Inspection of skin outside of affected area reveals no abnormalities.
HEENT:
Ears: Inspection reveals normal ear structure with no pits, sinus tracts or skin tags. Both ear canals are occluded by cerumen. Tympanic membranes are normal.
Nose: Mucosa of the nose is boggy, edematous and pale. Nasal turbinates are markedly swollen in both nostrils.
Mouth & pharynx: no notable oral lesions. No pharyngeal erythema or exudate. Tonsils not

enlarged.
Head: Patient's head is normocephalic, no gross bulging or retraction noted, no evidence of any mass or any osteomyelitis of skull bones evident.
Neck: Neck exam reveals no abnormalities. Thyroid examination reveals no abnormalities. Jugular veins examined with no distention or abnormal waves noted. No neck, supraclavicular, or axillary lymphadenopathy noted. No abnormalities of the hand, foot and nails.
Respiratory: Assessment of the repisratory effort reveals even respirations without the use of accessory muscles and no intercostal retractions noted. Auscultation of lungs reveals clear lung fields and no rubs noted.
Cardiovascular: Heart auscultation reveals normal S1 and S2 and no murmurs, gallop, rubs or clicks. No edema present bilateral lower extremities. The apical impulse on heart palpation is located in the left fifth intercostal space in the midclavicular line, no thrill noted. Carotid pulses are palpated bilaterally and are symmetric, no bruits are auscultated over the carotid and vertebral arteries. Abdominal aorta is of normal size without presence of systolic bruit. All peripheral pulses present and normal. Varicosities are not observed.
Musculoskeletal: There is no evidence of bony tenderness, joint effusion, enlargement or abnormal motion. No muscle fasciculations, atrophy, muscle weakness, asymmetry or reduced range of motion is noted.
Lymphatic: No lymph node enlargement or tenderness noted. There is no evidence of acute or chronic lymphedema.
Neurologic: Alert and oriented X 3. Cranial nerves II-XII are grossly intact. Strength 5/5 in all muscle groups. Sensation is intact to light touch and pinprick. Reflexes are equal and symmetric bilaterally in the upper and lower extremities. Babinski is negative. Cerebellar function grossly intact. Finger-to-nose coordination is within normal limits. Gait normal without ataxia.
Psychiatric: There are no anxiety, depression, mood swings or psychotic features. Patient's insight is good. Memory and judgement are intact.

Diagnosis:
401.9 Hypertension Not Otherwise Specified 381.81 Dysfunction of Eustachian Tube

Office Test:
URINALYSIS (81000)
Leukocytes: trace, Nitrite: negative, Urobilinogen: normal, Protein: negative, PH: 6, Blood: negative, S G: 1.010, Ketone: negative, Bilirubin: negative, Glucose: negative

HEMOCUE (85018)
HEMOCUE: 9.3

Plan:
STATUS: stable and needs improvement. MEDICATIONS: continue the current drug regimen and samples of Claritin given to take 1 daily prn. DIET: increase daily intake of water and No change. EXERCISE/ ACTIVITY/ LIFESTYLE: aerobic exercises.

Careplan:
(1) Cerumen Impaction

Followup:
RTO prn

This visit note has been electronically signed off by following providers.
This visit note has been electronically signed off by Joan Wynn Taylor, MD.

Medical Record Request Complete

release POINT

Customer Information

Report Date: October 19, 2012 RPID: 1509293

Client Name: Standard Insurance Company Claims

Req. By: STS AMURD

Patient Information

Name: SCOTT, L'TONYA L

D.O.B.: [redacted] Policy/Cert: VQ6781

Special Requirements:
Please obtain all medical records from 1/01/12 to present.

Provider Information

Provider: SMITH, DR DAVID
725 Long Point Rd.
ATTN: MEDICAL RECORDS
Mt. Pleasant, SC 29464

Phone: (843) 971-8180 Fax: (843) 375-2214

Electronic Order Data (If Applicable)

Patient Name: SCOTT, L'TONYA L
Patient DOB:
Patient SSN: [redacted]
Policy Number: VQ6781

RECEIVED
OCT 22 2012
EMPLOYEE BENEFITS

Provider Data: DR. DAVID KEVIN SMITH
1300 HOSPITAL DR STE 250

MOUNT PLEASANT, SC 29464
843-971-8180

R 519

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CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Supplemental Record on Appeal contains all material proposed to be included in Respondent's Amended Designation of Matter to be Included in the Record on Appeal and not any other matter.

September 29, 2017

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