

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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APPEAL FROM SOUTH CAROLINA  
Workers' Compensation Commission

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**RECEIVED**

**Sep 08 2020**

**SC Court of Appeals**

Appellate Case No.: 2017-001764

Op. No. 5726 (S.C. Ct. App, filed May 13, 2020) (Shearouse Adv. Sh. No. 19 at 75)

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Chisolm Frampton, Employee, ..... Appellant,

v.

S.C. Department of Natural Resources, Employer,  
and S.C. State Accident Fund, Carrier, ..... Respondents.

---

**SUPPLEMENTAL RECORD ON APPEAL**

---

**Attorneys for Appellant**

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SURGERY SCHEDULING SHEET

*file*

Surgeon: Barley

Patient's Name: Alexander Frampton

Dx/Code: 723.1

Procedure Codes: 63075, 76, 22554, 22585, 20931, 22845

Consent to Perform: ACDF C5/6 C6/7

Surgeon Positioned on Patient's:  Left  Right

Special Requests: c-arm / microscope / drill / surgical assist / Danek / Acromed / Synthes / Aesculap : \_\_\_\_\_

Procedure Date: 3/21/11 Surgery Time: \_\_\_\_\_ Admit Time: \_\_\_\_\_

Hospital: St Francis # of Hours: \_\_\_\_\_ PAT date/time: \_\_\_\_\_ Status: \_\_\_\_\_

Scheduled With: Laura Date: \_\_\_\_\_

In Patient's Notes: \_\_\_\_\_ In Appt Scheduler: \_\_\_\_\_ Told Patient: \_\_\_\_\_

Film Location: \_\_\_\_\_

Notes: \_\_\_\_\_

Alerts:  Cognitively Impaired  Nursing Home  Malignant Hyperthermia

Weight over 300 lbs.  MRSA/VRE

SCHEDULE FIRST PRE-OP APPT FOR: \_\_\_\_\_

Precertification Information

Insurance/Precert Co Name: BC STATE

Name of Contact: Donna Phone #: \_\_\_\_\_ Ext. #: \_\_\_\_\_

Precert/Authorization #: 1108008450323 x 2 day

Date Completed: 3/21/11

FRAMPTON, ALEXANDER C

11080-00605

03/21/11

03/22/11

F1  
17

ALEXANDER C FRAMPTON SR  
5296 DIXIE PLANTATION RD  
HOLLYWOOD

SELF

SC 29449

03/26/11 IPC

400400 BCBS STATE HEALTH PLAN

ZCS27344721

FRAMPTON, ALEXANDER

03/21/11	24	16200 ROOM 0504 P		1	1,317.00	1,317.00
		TOTAL R AND B PRIVATE MED GENERAL				1,317.00
03/21/11	13527339	1160SENNA 8.6 MG TAB		1	0.00	0.00
03/21/11	13533117	1766EPHEDRINE SULFATE (PRESSORS)		1	36.00	36.00
03/21/11	13533118	1839GLYCOPYRROLATE 0.4MG/2ML S		1	36.00	36.00
03/21/11	13533119	2150PROPOFOL 200MG/20ML EMUL		1	36.00	36.00
03/21/11	13533115	2169ROCURONIUM BROMIDE 50MG/5ML		1	36.00	36.00
03/21/11	13527340	217DOCUSATE SODIUM 100 MG CAP		1	0.00	0.00
03/21/11	13533114	2488LIDOCAINE HCL (2%) SOLN		1	36.00	36.00
03/21/11	13526770	3656GELATIN ADSORBABLE [SIZE 100]		1	92.75	92.75
03/21/11	13533112	3845DESFLURANE LIQD	180		6.00	1,080.00
03/21/11	13526769	3889BACITRACIN SOLUTION SOLR		1	36.00	36.00
03/21/11	13527346	3970MORPHINE SULFATE 5 MG/ML S		1	46.00	46.00
03/21/11	13527346	3970MORPHINE SULFATE 5 MG/ML S		1	46.00	46.00
03/21/11	13524587	4557LIDOCAINE HCL 1% (LOCAL ANE		1	36.00	36.00
03/21/11	13527270	4661SODIUM CHLORIDE FLUSH 0.9%		1	36.00	36.00
03/21/11	13527342	640CYCLOBENZAPRINE HCL 10 MG		1	2.50	2.50
03/22/11	13527329	1044OXYCODONE-ACETAMINOPHEN [5-3		2	4.50	9.00
03/22/11	13527419	1140QUINAPRIL HCL 20 MG TAB		1	2.50	2.50
03/22/11	13527339	1160SENNA 8.6 MG TAB		1	0.00	0.00
03/22/11	13527344	1287ZOLPIDEM TARTRATE 5 MG TAB		2	4.50	9.00
03/22/11	13527344	1287ZOLPIDEM TARTRATE 5 MG TAB		-1	4.50	4.50CR
03/22/11	13527340	217DOCUSATE SODIUM 100 MG CAP		1	0.00	0.00
03/22/11	13531595	3022LIDOCAINE HCL (2%) GEL		1	24.25	24.25
03/22/11	13533170	3143TAMSULOSIN HCL 0.4 MG CP24		1	21.75	21.75
03/22/11	13527462	3248CITALOPRAM HYDROBROMIDE 20 M		1	2.50	2.50
03/22/11	13527270	4661SODIUM CHLORIDE FLUSH 0.9%		1	36.00	36.00
03/22/11	13527335	468ACETAMINOPHEN 325 MG TAB		2	0.00	0.00
		TOTAL PHARMACY				1,655.75
03/21/11	13527322	1353NACL [0.9%] SOLP		1	48.00	48.00
03/21/11	13527322	1353NACL [0.9%] SOLP		2	48.00	96.00
		TOTAL PHARMACY IV SOLUTIONS				144.00
03/21/11	32	72504 BONE IMPLANT LEVEL 3		1	2,297.00	2,297.00
03/21/11	34	72504 BONE IMPLANT LEVEL 3		1	2,297.00	2,297.00
03/21/11	36	72630 SCREW/BOLT IMPLANT LEVEL 6		2	689.00	1,378.00

Patient:FRAMPTON, ALEXANDER C

MRN:000655963

Encounter:1108000605

Page 1 of 5

FRAMPTON, ALEXANDER C

11080-00605

03/21/11

03/22/11

F1  
17

ALEXANDER C FRAMPTON SR  
5296 DIXIE PLANTATION RD  
HOLLYWOOD SC 29449

SELF

03/26/11 IPC

400400 BCBS STATE HEALTH PLAN

EC827344721

FRAMPTON, ALEXANDER

03/21/11	37	72836	CERVICAL LEVEL 2	1	4,650.00	4,650.00
			TOTAL OTHER IMPLANTS			10,622.00
03/21/11	1	30130	KR C ARM (FLUORO MORE THAN 1	1	784.00	784.00
			TOTAL DIAGNOSTIC RADIOLOGY			784.00
03/21/11	35	55130	OR LEVEL IV INITIAL 30 MINS	1	5,696.00	5,696.00
03/21/11	31	55135	OR LEVEL IV EA ADD 30 MINS	6	2,847.00	17,082.00
			TOTAL OR SERVICES			22,778.00
03/22/11	29	42000	OT EVAL 15 MIN	1	151.00	151.00
			TOTAL EVALUATION OR REEVALUATION OT			151.00
03/21/11	13527322		15CEFAZOLIN SODIUM 1 GM SOLR	2	36.00	72.00
03/21/11	13527322		15CEFAZOLIN SODIUM 1 GM SOLR	4	36.00	144.00
03/21/11	13533116		1711DEKAMETHASONE SODIUM PHOSPHA	1	36.00	36.00
03/21/11	13524917		1799FENTANYL CITRATE 250MCG/5ML	1	46.00	46.00
03/21/11	13524912		1993MIDAZOLAM HCL 2MG/2ML SOLN	1	46.00	46.00
03/21/11	13533119		2029NEOSTIGMINE METHYLSULFATE 10	1	36.00	36.00
03/21/11	13527326		2038ONDANSETRON HCL 4 MG/2 ML	1	36.00	36.00
03/21/11	13524918		3972HYDROMORPHONE HCL 2 MG/ML	1	46.00	46.00
03/21/11	13524918		3972HYDROMORPHONE HCL 2 MG/ML	1	46.00	46.00
			TOTAL DRUGS REQUIRING DETAIL CODING			508.00
03/21/11	33	54132	PACU INITIAL 30 MINS	1	1,147.00	1,147.00
03/21/11	30	54134	PACU EA ADDL 30 MINS	1	426.00	426.00
			TOTAL RECOVERY ROOM			1,573.00

TOTAL CHARGES 39,532.75

TOTAL PAYMENTS/ADJUSTMENTS 0.00  
ESTIMATED PATIENT BALANCE DUE 0.00

39,532.75

Patient:FRAMPTON, ALEXANDER C

MRN:000655963

Encounter:1108000605

Page 2 of 5

ALEXANDER C FRAMPTON SR  
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03/21/11	13533118	1839GLYCOPYRROLATE 0.4MG/2ML S	1	36.00	36.00
03/21/11	13533113	2150PROPOFOL 200MG/20ML EMUL	1	36.00	36.00
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03/21/11	13527340	217DOCUSATE SODIUM 100 MG CAP	1	0.00	0.00
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03/21/11	13527342	640CYCLOBENZAPRINE HCL 10 MG	1	2.50	2.50
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03/22/11	13527344	1287ZOLPIDEM TARTRATE 5 MG TAB	-1	4.50	4.50CR
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FRAMPTON, ALEXANDER C

11080-00605

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03/22/11	29	42000	OT EVAL 15 MIN TOTAL EVALUATION OR REEVALUATION OT	1	151.00	151.00 151.00
03/21/11	13527322		15CEFZOLIN SODIUM 1 GM SOLR	2	36.00	72.00
03/21/11	13527322		15CEFZOLIN SODIUM 1 GM SOLR	4	36.00	144.00
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03/21/11	13533119		2029NEOSTIGMINE METHYLSULFATE 10	1	36.00	36.00
03/21/11	13527326		2038ONDANSETRON HCL 4 MG/2 ML	1	36.00	36.00
03/21/11	13524918		3972HYDROMORPHONE HCL 2 MG/ML	1	46.00	46.00
03/21/11	13524918		3972HYDROMORPHONE HCL 2 MG/ML TOTAL DRUGS REQUIRING DETAIL CODING	1	46.00	46.00 508.00
03/21/11	33	54132	PACU INITIAL 30 MINS	1	1,147.00	1,147.00
03/21/11	30	54134	PACU EA ADDL 30 MINS TOTAL RECOVERY ROOM	1	426.00	426.00 1,573.00
TOTAL CHARGES						39,532.75
03/31/11	749	10101	BCBS Electronic Payment	400400	16,587.42CR	
03/27/11	524	A0079	PCON PPO ADJUSTMENT	400400	21,034.75CR	

Patient: FRAMPTON, ALEXANDER C

MRN: 000635963

Encounter: 1108000605

Page 4 of 5



PRACTICE: \_\_\_\_\_ MR#: \_\_\_\_\_

**Patient Information**

Last Name: FRampton       Mr.   Mrs.   Miss      SSN: 250-31-2858  
 First Name: Alexander      Other title \_\_\_\_\_      Date of Birth:   /  /    
 Middle: Chisolm      (Doctor, General, the III, etc...)      Sex: Male  Female   
 Marital Status:  Married   Single   Separated   Divorced   Widowed   Relationship to Guarantor: \_\_\_\_\_  
 Student Status: Full   Part   N/A   School: \_\_\_\_\_      Phone: (   ) \_\_\_\_\_  
 Employment:  Full   Part   None   Employer: SCDNR      Phone: (843) 953-9307  
 Address: (This practice will send all correspondence to this address unless you provide us an alternate address below)  
 Street: 5296 Dixie Plantation Rd      City: Hollywood      State: SC      Zip: 29449  
 Phone: (843) 571-0053      (RSFH will contact you at this number unless you provide us an alternate number below)  
 May we leave a general voice message for appointment reminders at this contact phone number? Yes \_\_\_\_\_ No   
 May we leave a general voice message for normal test results at this contact phone number? Yes  No \_\_\_\_\_  
 In Case of Emergency Contact Name Lisa Frampton  
 Relationship Wife      Home Phone (   ) 571-0053      Work Phone (843) 970-5554

**Alternate Address**

Last Name: \_\_\_\_\_      Mr.   Mrs.   Miss      SSN: \_\_\_\_\_  
 First Name: \_\_\_\_\_      Other title \_\_\_\_\_      Date of Birth:   /  /    
 Middle: \_\_\_\_\_      (Doctor, General, the III, etc...)      Sex: Male  Female   
 Address: \_\_\_\_\_      Phone: Home (   ) \_\_\_\_\_  
 City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_      Phone: Work (   ) \_\_\_\_\_  
 (Complete only if you want the Practice to communicate with you at an address/phone different than you provided above)  
 Alternate Address: \_\_\_\_\_      Alternate Phone: (   ) \_\_\_\_\_  
 City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_

Member/Policyholder (if different from patient)		Member/Policyholder (if different from patient)	
<u>SCBCBS</u>			
Member/Policyholder ID# <u>2CS 2934721</u>	Date of Birth <u>5/27/65</u>	Member/Policyholder ID#	Date of Birth
Insurance Co. Phone Number (   )	Group #	Insurance Co. Phone Number (   )	Group #
Insurance Co. Address (Street Address/ P.O. Box)		Insurance Co. Address (Street Address/ P.O. Box)	
City	State	Zip	

**Disclosure, Communication, and Access to Health Information**

We may release/discuss your health information with following individuals/organizations for the following dates of service, range of time, or event(s): From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
<u>Tim Jones</u>	_____	_____	<u>Phy.</u>
<u>John Davis</u>	_____	_____	<u>Phy.</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate authorization must be completed if the information being release differs between the individuals/organizations listed above.

**Authorization, Assignment of Benefits, and Referral Medical Release**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Roper Saint Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

I have been provided a copy of the Roper Saint Francis Healthcare Notice of Information Practices.

Signed: Alexander Charles Hampton Date 3 / 16 / 10

Office Use Only:



**Authorization to Release Medical Information**

We may release/discuss your health information with following individuals/organizations for the following dates of service, range of time, or event(s): From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate authorization must be completed if the information being release differs between the individuals/organizations listed above.

Guarantor Email Address: Franpton Co DNR, SC, GOV

**Authorization to Release Medical Information**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Roper Saint Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

I have been provided a copy of the Roper Saint Francis Healthcare Notice of Information Practices.

Signed: AC Franpton Date 3 11 11

Office Use Only:

**Patient Information**

Last Name: FRAMPTON  
 First Name: Alex  
 Middle Name: Chisolm  
 Address: 2431 Royal Oak P. City: Chas County: Chs State: SC Zip: 29455  
 Email Address: FRAMPTON@DNR.SC.GOV  
 Home Phone: ( ) Cell Phone: (843) 870-5554 Work Phone: (803) 734-4004  
 Date of Birth: 5/27/65 Age: 50 Sex: Male  Female   
 Preferred Name: Chisolm SSN: 202 31 2858  
 May we leave a message about appointments or normal test results on the phone numbers you provided? Yes  No   
 Would you like to receive appointment reminders via text message? Yes  No  (If yes, please provide cell phone number above.)  
 Marital Status:  Married  Single  Separated  Divorced  Widowed  Partner  Unknown  
 Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Other:  
 Primary Language:  English  Spanish  French  Other:  
 Race:  Caucasian  African American  Asian  Other:  
 Student Status:  Not a Student  Full  Part  
 Employment Status:  Full  Part  N/A Employer: SC DNR  
 Pharmacy name: CVS Address: LA HABANA WAY Phone: ( )  
 Emergency Contact: Name: Lisa Frampton Relationship: Wife Phone: ( ) 5689089  
 Alternate Contact: If you want this Practice to contact you at an alternate address or telephone number, please complete:  
 Alt. Address: City: State: Zip: Phone: ( )  
 Referred by: Primary Care Physician: John Davis

**Guarantor/Financially Responsible Person (if different from patient)**

Last Name: First Name: Middle: Address: Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )  
 Date of Birth: / / Age: SSN: Relationship to Patient: City: State: Zip: Sex: Male Female  
 Guarantor/Financially Responsible Person's Email Address:

**Primary Insurance**

Insurance Company: BCBS  
 Policyholder Name: Alexander C Frampton  
 Member or Policyholder ID#:   
 Policyholder Date of Birth: 5/27/65  
 Insurance Co. Phone #:   
 Group#: State 7 SC  
 Relationship to Patient:

**Secondary Insurance**

Insurance Company:   
 Policyholder Name:   
 Member or Policyholder ID#:   
 Policyholder Date of Birth:   
 Insurance Co. Phone #:   
 Group#:   
 Relationship to Patient:

## Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release

**CONSENT FOR TREATMENT:** I consent and authorize a Roper St. Francis Physician Partners ("RSFPP") physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFPP Notice of Privacy Practices, a copy of which has been made available to me.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign all my rights and allow payment to be made directly to RSFPP for all medical or surgical benefits otherwise payable to me under terms of my insurance.

**PAYMENT GUARANTEE:** I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by RSFPP, including charges for services not covered by my insurance. I consent and authorize RSFPP and third party agents of RSFPP to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep RSFPP informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: Alex C Jeannotte

Patient's Signature: [Signature]

Print Legal Guardian's Name: \_\_\_\_\_

Legal Guardian's Signature: \_\_\_\_\_

Date: 5/22/16

Date:     /    /    

## Ongoing Communication Regarding Your Healthcare

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM RSFPP MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Please provide the information below.)**

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize RSFPP to release and/or discuss your health information with the following people or organizations for the specific dates of service or event(s). Any revocation or modification to your authorization with regard to an individual or organization must be submitted in writing.

**PLEASE NOTE:** By listing an individual(s)/entity(s) below, you authorize **ALL** RSFPP physician offices to release and/or discuss your health information with the individual(s)/entity(s). If you wish to **EXCLUDE** certain RSFPP physician offices/practice areas from releasing and/or discussing your health information with the individual(s)/entity(s), please indicate that below.

From date of service/event(s): \_\_\_\_\_

To date of service/event(s): \_\_\_\_\_

Name of Individual/Entity

Phone Number

Relationship

RSFPP Physician Office(s)

*Example: John Doe*

*843-555-1212*

*Husband*

Exclude: *OB/GYN, Urology*

*Lisa Jeannotte*

*568-1089*

*Wife*

Exclude: \_\_\_\_\_

Exclude: \_\_\_\_\_

Exclude: \_\_\_\_\_

A separate Authorization to Release Information Form must be completed for any individual(s)/entity(s) not listed in the section above. To request restrictions of the use of your information, you must complete a separate Request For Restrictions Form.

Please identify below the individual(s) that you authorize to receive prescriptions from your RSFPP provider(s). For the individual(s) identified below, you may authorize (1) **ALL** prescriptions or (2) **EXCLUDE** certain prescriptions.

Name of Individual

Phone Number

Relationship

Prescription(s)

All  Exclude: \_\_\_\_\_

All  Exclude: \_\_\_\_\_

All  Exclude: \_\_\_\_\_

1012533CHISOLM A 09/04/10	State Accident Fund	FOR: State Accident Fund	John C Land, III Land Parker & Welch, PA PO Box 138 Manning SC 29102 john@lpwlawfirm.com (803) 435-8894	03/11/20 Form 18 Received 09/09/19 Form 18 Received 03/07/19 Form 18 Received 09/10/18 Form 18 Received 03/08/18 Form 18 Received 09/08/17 Form 18 Received 08/28/17 Notice of intent to appeal to Court of Appeals 07/24/17 Order Assigned to be Written 07/24/17 Order Served 03/31/17 Order Assigned to be Written 03/10/17 Form 18 Received 01/23/17 Notice Printed 01/23/17 Scheduled for appeal hearing 01/12/17
FRAMPTON	P.O. Box 102100	Erin Farthing		
-VS- DEPT	Columbia SC 29221	State Accident Fund		
OF	bblack@saf.sc.gov	PO Box 102100		
NATURAL	(800) 521-6576	Columbia SC 29221	Blake A. Hewitt Bluestein Nichols Thompson Delgado LLC P O Box 7965 Columbia SC 29202 bhewitt@bntdlaw.com (803) 779-7599	
RESOURCES		FOR: State Accident Fund		
		Kirsten L. Barr		
		Trask & Howell, LLC		
		PO Box 2167		
		Mt. Pleasant SC 29465	Stephen B. Samuels Samuels Reynolds Law Firm 1320 Richland Street Columbia SC 29201 stephen@samuelsreynolds.com (803) 779-4000	
		kbarr@trask-howell.com		
		(843) 881-4228		

Appeal  
Hearing  
Postponed  
01/12/17  
Notice  
Printed  
01/09/17  
Appellate  
Reply Brief  
Uploaded  
through  
eCase by  
JOHN C  
LAND, III  
(CLT)  
01/05/17  
Respondent  
Brief  
Uploaded  
through  
eCase by  
KIRSTEN L.  
BARR  
(CAR)  
01/03/17  
Notice  
Printed  
01/03/17  
Scheduled  
for appeal  
hearing  
12/30/16  
Appellants  
Brief  
received  
12/22/16  
Appellant  
Brief  
Uploaded  
through  
eCase by  
KIRSTEN L.  
BARR  
(CAR)  
12/20/16  
Appellants

Brief  
received  
12/20/16  
Appellant  
Brief  
Uploaded  
through  
eCase by  
JOHN C  
LAND, III  
(CLT)  
11/23/16  
Notice  
Printed  
11/22/16  
Scheduled  
for appeal  
hearing  
10/20/16  
Ready to  
set for  
Appeal  
Hearing  
10/20/16  
Oral  
Argument  
requested  
10/20/16  
Appeal filed  
10/19/16  
Ready to  
set for  
Appeal  
Hearing  
10/19/16  
Oral  
Argument  
requested  
10/19/16  
Appeal filed  
10/04/16  
Order  
Served  
09/08/16  
Form 18  
Received

03/09/16  
Form 18  
Received  
02/16/16  
Order  
Assigned to  
be Written  
09/14/15  
Form 18  
Received  
07/29/15  
Hearing  
Held  
07/17/15  
APA  
Uploaded  
through  
eCase by  
JOHN C  
LAND, III  
(CLT)  
07/16/15  
APA  
Uploaded  
through  
eCase by  
KIRSTEN L.  
BARR  
(CAR)  
07/16/15  
Exhibits  
Uploaded  
through  
eCase by  
KIRSTEN L.  
BARR  
(CAR) by  
KIRSTEN L.  
BARR  
(CAR)  
07/03/15  
Pre-  
Hearing  
Brief  
Uploaded  
through

eCase by  
KIRSTEN L.  
BARR  
(CAR)  
06/25/15  
Pre-  
Hearing  
Brief  
Uploaded  
through  
eCase by  
JOHN C  
LAND, III  
(CLT)  
05/13/15  
Notice  
Printed  
05/13/15  
Scheduled  
for Hearing  
04/24/15  
Hearing  
Schedule  
Pending  
04/24/15  
Mediation  
Impasse  
03/24/15  
Mediation  
Scheduled  
03/09/15  
Form 18  
Received  
03/09/15  
Claim  
Reviewed  
by  
Examiner  
12/08/14  
Mediation  
Mandated  
12/08/14  
Form 51  
Timely  
12/08/14  
Form

51/53/55  
Received  
11/20/14  
Form 18  
Received  
11/18/14  
Form 50  
Hearing  
requested  
09/09/14  
Form 18  
Received  
09/09/14  
Claim  
Reviewed  
by  
Examiner  
03/07/14  
Form 18  
Received  
09/09/13  
Form 18  
Received  
03/07/13  
Form 18  
Received  
09/07/12  
Form 18  
Received  
03/09/12  
Form 18  
Received  
09/08/11  
Form 18  
Received  
07/29/11  
Form 17  
Received  
07/12/11  
Form 20  
Received  
07/08/11  
Claim  
Reopened  
07/08/11  
Temp.

Comp.  
Award  
Started  
09/28/10  
Claim  
Closed  
09/23/10  
Form 19  
Received

11/03/17

M94

FRAMPTON, ALEXANDER C

11080-00605

03/21/11

03/22/11

002

D2

18

ALEXANDER C FRAMPTON SR

2431 ROYAL OAK DR

JOHNS ISLAND

SC 29455

SELF

03/26/11 IPC

622001 STATE ACCIDENT FUND

400400 BCBS STATE HEALTH PLAN

2010-003478

EC827344721

FRAMPTON, ALEXANDER, C

FRAMPTON, ALEXANDER

03/21/11	37	72836	CERVICAL LEVEL 2	1	4,650.00	4,650.00
			TOTAL OTHER IMPLANTS			10,622.00
03/21/11	1	30130	XR C ARM (FLUORO MORE THAN 1	1	784.00	784.00
			TOTAL DIAGNOSTIC RADIOLOGY			784.00
03/21/11	35	55130	OR LEVEL IV INITIAL 30 MINS	1	5,696.00	5,696.00
03/21/11	31	55135	OR LEVEL IV EA ADD 30 MINS	6	2,847.00	17,082.00
			TOTAL OR SERVICES			22,778.00
03/22/11	29	42000	OT EVAL 15 MIN	1	151.00	151.00
			TOTAL EVALUATION OR REEVALUATION OT			151.00
03/21/11	13527322		15CFEPAZOLIN SODIUM 1 GM SOLR	2	36.00	72.00
03/21/11	13527322		15CFEPAZOLIN SODIUM 1 GM SOLR	4	36.00	144.00
03/21/11	13533116		1711DEKAMETHASONE SODIUM PHOSPHA	1	36.00	36.00
03/21/11	13524917		1799FENTANYL CITRATE 250MCG/5ML	1	46.00	46.00
03/21/11	13524912		1993MIDAZOLAM HCL 2MG/2ML SOLN	1	46.00	46.00
03/21/11	13533119		2029NEOSTIGMINE METHYLSULFATE 10	1	36.00	36.00
03/21/11	13527326		2038ONDANSETRON HCL 4 MG/2 ML	1	36.00	36.00
03/21/11	13524918		3972HYDROMORPHONE HCL 2 MG/ML	1	46.00	46.00
03/21/11	13524918		3972HYDROMORPHONE HCL 2 MG/ML	1	46.00	46.00
			TOTAL DRUGS REQUIRING DETAIL CODING			508.00
03/21/11	33	54132	PACU INITIAL 30 MINS	1	1,147.00	1,147.00
03/21/11	30	54134	PACU EA ADDL 30 MINS	1	426.00	426.00
			TOTAL RECOVERY ROOM			1,573.00
			TOTAL CHARGES			39,532.75
03/31/11	749	I0101	BCBS Electronic Payment	400400	16,587.42CR	
08/16/11	611	I0007	WORKERS COMP PAYMENT	622001	17,448.79CR	
03/27/11	524	A0079	PCON PPO ADJUSTMENT	400400	21,034.75CR	
07/07/11	745	A0089	PCON COMM/INDEMNITY ADJUSTMENTS	622001	22,045.48CR	
07/07/11	744	A0079	PCON PPO ADJUSTMENT	400400	21,034.75	
08/18/11	765	A0089	PCON COMM/INDEMNITY ADJUSTMENTS	622001	38.48CR	

FRAMPTON, ALEXANDER C	11080-00605	03/21/11	03/22/11	11/03/17 M94 003 D2 18
ALEXANDER C FRAMPTON SR 2431 ROYAL OAK DR JOHNS ISLAND	SC 29455	SELF	03/26/11	IPC
622001 STATE ACCIDENT FUND	2010-003478			FRAMPTON, ALEXANDER, C
400400 BCBS STATE HEALTH PLAN	BCS27344721			FRAMPTON, ALEXANDER

08/18/11	765	A0075 MANAGED CARE VARIANCE	622001	38.48
08/18/11	747	A0075 MANAGED CARE VARIANCE	622001	38.48CR
08/22/11		D0001 CARRIER REFUND APPROVED	400400	16,587.42
TOTAL PAYMENTS/ADJUSTMENTS				39,532.75CR
ESTIMATED PATIENT BALANCE DOE				0.00

PLEASE SEND YOUR PAYMENT TO:

BON SECOURS ST. FRANCIS HOSPITAL  
PO BOX 751874  
CHARLOTTE, NC 28275-1874

0.00

FRAMPTON, ALEXANDER C      11080-00605      03/21/11      03/22/11      001  
M94  
D2  
18

ALEXANDER C FRAMPTON SR      SELF  
2431 ROYAL OAK DR  
JOHNS ISLAND      SC 29485      03/26/11      IPC

622001 STATE ACCIDENT FUND      2010-003478      FRAMPTON, ALEXANDER, C  
400400 BCBS STATE HEALTH PLAN      ZCS27344721      FRAMPTON, ALEXANDER

0110 R AND B PRIVATE MED GENERAL	1,317.00
0250 PHARMACY	1,655.75
0258 PHARMACY IV SOLUTIONS	144.00
0278 OTHER IMPLANTS	10,622.00
0320 DIAGNOSTIC RADIOLOGY	784.00
0360 OR SERVICES	22,778.00
0434 EVALUATION OR REEVALUATION OT	151.00
0636 DRUGS REQUIRING DETAIL CODING	508.00
0710 RECOVERY ROOM	1,573.00

TOTAL CHARGES      39,532.75

03/31/11	749	I0101 BCBS Electronic Payment	16,587.42CR
08/16/11	611	I0007 WORKERS COMP PAYMENT	17,448.79CR
03/27/11	S24	A0079 PCOM PPO ADJUSTMENT      400400	21,034.75CR
07/07/11	745	A0089 PCOM COMM/INDEMNITY ADJUSTMENT622001	22,045.48CR
07/07/11	744	A0079 PCOM PPO ADJUSTMENT      400400	21,034.75
08/18/11	765	A0089 PCOM COMM/INDEMNITY ADJUSTMENT622001	38.48CR
08/18/11	765	A0075 MANAGED CARE VARIANCE      622001	38.48
08/18/11	747	A0075 MANAGED CARE VARIANCE      622001	38.48CR
08/22/11	D0001	CARRIER REFUND APPROVED      400400	16,587.42

TOTAL PAYMENTS/ADJUSTMENTS      39,532.75CR  
ESTIMATED PATIENT BALANCE DUE      0.00

PLEASE SEND YOUR PAYMENT TO:  
BON SECOURS ST. FRANCIS HOSPITAL  
PO BOX 751874  
CHARLOTTE, NC 28275-1874

0.00

C:10800605 1 3

BON SECOURS ST FRANCIS 2095 HENRY TECKLENSBURG DR CHARLESTON SC 29414 8434023200	BON SECOURS ST FRANCIS P.O. BOX 751874 CHARLOTTE NC 28275	REF ID: C110800605 REG: 000655963 DATE: 032111 TIME: 032111
---	---	--

FRAMPTON SR, ALEXANDER, C 05271965 M 11 032111	HOLLYWOOD 5296 DIXIE PLANTATION RD SC 29449
--	---

FRAMPTON SR, ALEXANDER, C 5296 DIXIE PLANTATION RD HOLLYWOOD SC 29449
--

DESCRIPTION	AMOUNT	DATE	STATUS
0110 R AND D PRIVATE MED CLINIC	1317.00		
0250 PHARMACY			
0258 PHARMACY IV SOLUTIONS			
0278 OTHER IMPLANTS			
0323 DIAGNOSTIC RADIOLOGY			
0380 OR SERVICES			
0434 EVALUATION OR REEVALUATI			
0636 DRUGS REQUIRING DETAIL C			
0712 RECOVERY ROOM			

0001 PAGE 1 OF 1 CREATION DATE 070811 TOTALS 3953275

622 STATE ACCIDENT FUND	Y	Y	Y	851361778
400 BCBS STATE HEALTH	Y	Y	Y	

FRAMPTON, ALEXANDER, C	C1 2010-003478	899999
FRAMPTON, ALEXANDER	C1 2CS27844721	002034400

1108008450329	1087039550000	SC DEPT OF NAT RESOURCES
7210 Y4019		SC DEPT OF NAT RESOURCES

7210	473	1508804857	BYRON, N
8102	032111	8051	032111

STATE ACCIDENT FUND	83282HC0000X	BYRON, N
P O BOX 102100		

NLBC



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

WCC #: 1012533  
Carrier File: 2010-003478  
Carrier Code #: 500-SF  
Employer FEIN #: 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
(843) 571-0053 (home) (work)

DEPT OF NATURAL RESOURCES  
1000 Assembly St., Rm. 249, Columbia, SC 29202

Preparer's name: Robert Peppers (803) 896-5924 State Accident Fund, Insurance Carrier

Date of injury: 09/04/2010 Date of notice to employer of injury: 09/07/2010

- I. Payment of Temporary Compensation (choose A, B, or C) (X) Initial period ( ) Additional period ( ) Corrected compensation rate
- A. Temporary Total at the compensation rate of \$ per week. For this period of disability, disability began on and the date of first payment was
- B. Temporary Partial at the compensation rate of \$ per week. Note: When Temporary Partial compensation rate will vary, report first payment here. Supplement throughout the period of Temporary Partial compensation by filing Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on and the date of first payment was

Calculation of Temporary Partial rate:

Average weekly wage before injury	\$
MINUS Current weekly wage	\$
Difference in wages before injury and now	\$
Temporary Partial Compensation Rate	\$

C. Salary in lieu of Temporary Total compensation in the amount of \$ 1299.31 per week. For this period of disability, disability began on 03-21-2011 and the date of first payment was 03-21-2011.

**THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF THE INJURY, ATTACH DOCUMENTATION AS TO THE REASON FOR THE TERMINATION.**

- II. Termination of Temporary Compensation. Temporary compensation payments were stopped on for the following reason:
- ( ) Claimant has returned to work at least 15 days and no temporary partial compensation is due.
- ( ) Claimant agrees he/she is able to return to work and has signed a Form 17.
- ( ) Based on a good faith investigation, the claim is denied. Reason for denial:
- ( ) Claimant has been released to return to work without restrictions and employment has been offered.
- ( ) Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
- ( ) Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator

Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:  
The employer's representative may stop temporary compensation within 150 days of the date of notice for the above reasons. However, if you believe that temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to the SCWCC Judicial Department at the address at the top of the form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(II)  has  has not been received.

Signature of claimant or legal representative

Date

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.07-1603. Employer's representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 - SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
(843) 571-0053 (home) (work)

DEPT OF NATURAL RESOURCES  
1000 Assembly St., Rm. 249, Columbia, SC 29202

Preparer's name: Robert Peppers (803) 896-5924 State Accident Fund, Insurance Carrier

Date of injury: 09/04/2010

1. Temporary Compensation Paid:

TT-AN	Number of Weeks	From	To	Amount
	6.00	21-MAR-11	01-MAY-11	

2. The claimant returned to work on 05/02/2011

More on page two...

With restrictions but at a salary not less than before the injury  
 Without restrictions.

3. The claimant agrees he or she was able to return to work on 05/02/2011

I agree that I was disabled for the period(s) indicated and I was paid compensation as shown above. I UNDERSTAND THAT MY WEEKLY TEMPORARY COMPENSATION CHECKS WILL STOP; HOWEVER, I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT, OR MEDICAL CARE. The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work or agree I was able to return to work.

\* Alexander C. Deard  
Claimant's Signature

Robert L. Peppers 7/27/11  
Employer's Representative Signature

Witness  Claimant's Attorney

Date Agreement Signed

File this form with the Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 day period, obtain a Form 17 to document that claimant agrees he or she is able to return to work.

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
Wk#:( ) - Home#:(843) 571-0053

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Robert Peppers (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year

2. Total Weeks of Compensation Paid: 6

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:

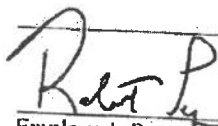
month day year

5. Total Amount Paid (a) Compensation: \$

(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 18,610.98

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

  
Employer's Representative

803-896-5924  
Phone #

09/05/2011  
Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's file is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request and informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

WCC FORM # 18 REV. DATE 3/96

18

PERIODIC REPORT

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
Wk#:( ) - Home#:(843) 571-0053

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year

2. Total Weeks of Compensation Paid: 6

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:

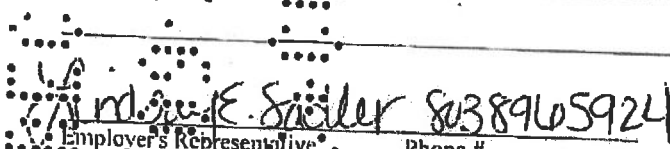
month day year

5. Total Amount Paid (a) Compensation: \$

(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 24,879.43

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

  
Employer's Representative Phone #

03/05/2012  
Date

Type or print information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request and informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

WCC FORM # 18 REV. DATE 3/96

18

PERIODIC REPORT

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
Wk#:( ) - Home#:(843) 571-0053

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year

2. Total Weeks of Compensation Paid: 6

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:

month day year

5. Total Amount Paid (a) Compensation: \$

(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 24,879.43

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

*Lindsay E. Sadler* 8038965924  
Employer's Representative Phone #

09/04/2012  
Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request and informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

WCC FORM # 18 REV. DATE 3/96

18

PERIODIC REPORT

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
Wk#:( ) - Home#:(843) 571-0053

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year
2. Total Weeks of Compensation Paid: 6
3. Type of Compensation Paid (TP or TT)/Periods of Payment:  
Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:  
month day year

5. Total Amount Paid (a) Compensation: \$  
(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 24,946.74

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

L. Sadler 8038965924  
Employer's Representative Phone #

03/04/2013  
Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request and informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

WCC FORM # 18 REV. DATE 3/96

18

PERIODIC REPORT

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
Wk#:( ) - Home#:(843) 870-5554

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year

2. Total Weeks of Compensation Paid: 6

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:

month day year

5. Total Amount Paid (a) Compensation: \$

(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 25,322.82

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

L. Sadler 8038965924  
Employer's Representative Phone #

09/04/2013  
Date

09042013

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's file is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request and informal conference. Refer to R.67-433.R.375, 507, and R.67-804 for further information.

WCC FORM # 18 REV. DATE 3/96

18

PERIODIC REPORT

09042013

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
5296 Dixie Plantation Road, Hollywood, SC 29449  
Wk#:( ) - Home#:(843) 870-5554

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year

2. Total Weeks of Compensation Paid: 6

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:

month day year

5. Total Amount Paid (a) Compensation: \$

(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 25,322.82

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*L. Sadler* 8038965924  
Employer's Representative Phone #

03/04/2014

Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number of concussions and informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

WCC FORM # 18 REV. DATE 3/96

18

PERIODIC REPORT

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
2431 Royal Oak Dr, Johns Island, SC 29455  
Wk#:(803) 734-4004 Home#:(843) 870-5554

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202.

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010

month day year

2. Total Weeks of Compensation Paid: 6

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:

month day year

5. Total Amount Paid (a) Compensation: \$

(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 25,322.82

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

*L. Sadler* 803 896 5924  
Employer's Representative Phone #

09/04/2014  
Date

0904

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request an informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

18

WCC FORM # 18 REV. DATE 3/96

PERIODIC REPORT

034

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
2431 Royal Oak Dr, Johns Island, SC 29455  
Wk#:(803) 734-4004 Home#:(843) 870-5554

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year
2. Total Weeks of Compensation Paid: 6
3. Type of Compensation Paid (TP or TT)/Periods of Payment:  
Type: TT-AN From: 03/21/2011 To: 05/01/2011

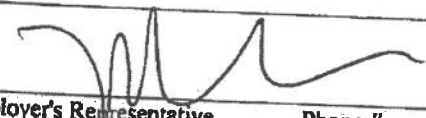
4. Date of First Payment:  
month day year

5. Total Amount Paid (a) Compensation: \$  
.....  
..... (b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 25,413.07

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

.....  
.....  
.....  
.....

  
Employer's Representative Phone #

11/17/2014  
Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request and informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

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

WCC File # 1012533  
Carrier File # 2010-003478  
Carrier Code # 500 SF  
Employer FEIN 570000P24

Alexander Frampton 250-31-2858  
2431 Royal Oak Dr, Johns Island, SC 29455  
Wk#:(803) 734-4004 Home#:(843) 870-5554

DEPT OF NATURAL RESOURCES  
1000 Assembly Street Room 136, Columbia, SC 29202

Preparer's name: Lindsay Sadler (803) 896-5924

State Accident Fund, Insurance Carrier

1. Date of injury: 09/04/2010  
month day year
2. Total Weeks of Compensation Paid: 6
3. Type of Compensation Paid (TP or TT)/Periods of Payment:  
Type: tt-an From: 03/21/2011 To: 05/01/2011

4. Date of First Payment:  
month day year

5. Total Amount Paid (a) Compensation: \$  
(b) Medical (Include Nursing, Hospital Drugs, Etc.): \$ 25,413.07

6. Informal Conference is Requested: ( ) yes (x) no  
(check one)

7. Use these lines to send a memo to the Commission:

.....

.....

.....

.....

.....

L. Sadler 8038965924  
Employer's Representative Phone #

03/04/2015  
Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request and informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

**RECEIVED**

**Sep 08 2020**

**SC Court of Appeals**

APPEAL FROM SOUTH CAROLINA  
Workers' Compensation Commission

Appellate Case No.: 2017-001764

Op. No. 5726 (S.C. Ct. App, filed May 13, 2020) (Shearouse Adv. Sh. No. 19 at 75)

Chisolm Frampton, Employee, ..... Appellant,

v.

S.C. Department of Natural Resources, Employer,  
and S.C. State Accident Fund, Carrier, ..... Respondents.

**CERTIFICATE OF COUNSEL**

The undersigned hereby certifies that this Supplemental Record on Appeal contains all material proposed to be included by any of the parties and not any other material.



Stephen B. Samuels  
Samuels Reynolds Law Firm, LLC  
1320 Richland Street  
Columbia, SC 29201  
(803) 779-4000  
Stephen@samuelsreynolds.com

Attorney for Appellant

September 8, 2020  
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

**RECEIVED**

**Sep 08 2020**

APPEAL FROM SOUTH CAROLINA  
Workers' Compensation Commission

**SC Court of Appeals**

Appellate Case No.: 2017-001764

Chisolm Frampton, ..... Appellant,

v.

SC Department of Natural Resources, Employer, and  
The State Accident Fund, Carrier, ..... Respondents.

**PROOF OF SERVICE**

I certify that I, Wanda Powell, paralegal to Stephen B. Samuels have caused the **Supplemental Record on Appeal** to be served upon the below parties on September 8, 2020, addressed as follows:

Kirsten L. Barr, Esquire  
Trask & Howell, LLC  
P.O. Box 2167  
Mt. Pleasant, SC 29465  
*via email: kbarr@trask-howell.com*



Wanda Powell  
Paralegal to Stephen B. Samuels

September 8, 2020  
Columbia, South Carolina



STEPHEN B. SAMUELS  
P. JASON REYNOLDS  
ATTORNEYS AT LAW

September 8, 2020

Via email: [ctappfilings@sccourts.org](mailto:ctappfilings@sccourts.org)

The Honorable Jenny Abbott Kitchings  
Clerk of the South Carolina Court of Appeals  
1220 Senate Street  
Columbia, SC 29201

**RECEIVED**

**Sep 08 2020**

**SC Court of Appeals**

RE: Chisolm Frampton v. S.C. Department of Natural Resources  
Appellate Case No.: 2017-001764

Dear Ms. Kitchings:

Attached for filing please find Appellant's **Supplemental Record on Appeal and Proof of Service** in the above-referenced case.

By copy of this letter and attachment to Kirsten L. Barr, counsel of record for Respondents, we are serving her with a copy of our **Supplemental Record on Appeal** as indicated by the attached **Proof of Service**.

Please have your staff clock in the **Supplemental Record on Appeal and Proof of Service** and return the clocked copies via email.

Thank you for your consideration in this matter. Please contact us with any questions or if further information is needed from our office.

With kindest regards, I am

Respectfully,

A handwritten signature in blue ink, appearing to be 'SBS', written over a horizontal line.

Stephen B. Samuels

SBS/wp  
Enclosure(s) as stated

cc: Kirsten L. Barr, Esquire (w/encls.)  
John C. Land, III (w/encls.)

WE WORK FOR THE PEOPLE WHO WORK