DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers/FOIA	12-10-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101262	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Stenoland, Singleton	[ ] Prepare reply for appropriate signature DATE DUE _____ FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Change to N/A per Marie Brown on 12/15/10, this is a routine document they receive. No logging necessary.			
2.			
3. ~~X~~ Cleared 12/22/10, letter attached.			
4.			

Brenda James - Keno L. Tolen

From: "Karen Kaminer" <karen@mttlaw.com>
To: <stensland@scdhhs.gov>
Date: 12/10/2010 3:40 PM
Subject: Keno L. Tolen
Attachments: 4011.PDF

Attached is the Request for Medicaid Payment Itemization we discussed a short while ago. Thank you for your help with this.

Karen B. Kaminer
Legal Assistant to Stanley L. Myers
Moore, Taylor & Thomas, P.A.
1700 Sunset Boulevard
Post Office Box 5709
West Columbia, South Carolina 29171
(803) 796-9160 - office
(803) 454-1866 - direct
(803) 791-8410 - fax

Brenda James - Fwd: Keno L. Tolen

From: Jeff Stensland
To: jamesbr@scdhhs.gov
Date: 12/10/2010 3:42 PM
Subject: Fwd: Keno L. Tolen
Attachments: Keno L. Tolen

FOIA resent

Jeff Stensland
SC DHHS
(803) 898-2584

Request for Medicaid Payment Itemization

TODAY'S DATE: 11/4/2010

Client's Name: Keno Tolen Medicaid ID or SSN: 591-50-1687

Parent's Name(s) if minor: _____ SSN: 591-50-1687

Date of Accident: 7/4/10 Date of Birth: 3/8/1987

Is Client Deceased? ___Yes ✓ No If Yes, Date of Death: _____

Estate Probated? ___ Yes ___No If Yes, Date Probated: _____ County: _____

Plaintiff's Attorney of Record: Stanley L. Myers

Name of Law Firm: Moore, Taylor & Thomas, P.A.

Mailing Address: P.O. Box 5709 29171

Telephone#: (803) 796-9160 Fax: (803) 791-8410 Contact Person: Karen Kominer or Ann Hampton

How was the client injured? Pedestrian v. Vehicle MVA

Briefly describe the client's injuries: Brain injury, scapula fracture, clavicle fracture, rib fracture, fibular neck fracture

Last date treated: ongoing Still Treating? : ✓ Yes _____No

Does your firm represent anyone else who was involved in this accident? If so, please provide name(s) and SSN(s). No

Insurance information:

(1) Liability Carrier

Ins. Co. Name: Progressive Claims

Address: 107 Westpark Blvd, Suite 200 Columbia SC 29210

Insured: Eric Rhodin

Claim#: Unknown

Adjuster: Lisa Cox

Phone#: (803) 740-7745

Policy limits: $25,000.00

(2) Other (specify) ____MIM ____UM ____Other

Ins. Co. Name: _____

Address: _____

_____

Insured: _____

Claim#: _____

Adjuster: _____

Phone#: _____

Policy limits: _____

Has suit been filed? _____Yes ✓ No

Please provide the name and address of the defense attorney(s):

_____

_____

Has this case settled? ✓ Yes ____ No How Much? _____

More to Come? _____Yes ✓ No Disbursed? _____Yes ✓ No Date: _____

Upon completion, please fax to (803) 255-8225

Or mail to:

Department of Health & Human Services

Accountability and Collections - Casualty Department

Post Office Box 100127, Columbia, SC 29202-3127

(OVER)

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford• Governor

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	_____ Hours	$_____
Pages copied at $.10 per page	_____ Pages	$_____
Pages faxed at $.20 per page	_____ Pages	$_____
Shipping and Handling Costs		$_____
Other costs associated with the FOIA request: _____		$_____
Total Amount Due SCDHHS:		**$_____**

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

_____ _____
Signature Date:

Finance and Administration
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2503 • Fax (803) 255-8235

Log # 00262

South Carolina Department of Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

December 22, 2010

Stanley L. Myers, Esquire
Moore, Taylor & Thomas, P.A.
ATTN: Karen B. Kaminer
Post Office Box 5709
West Columbia, South Carolina 29171

RE: Keno L. Tolen
Medicaid Number: 563 026 5660
Date of Accident: July 4, 2010

Dear Mr. Myers:

Enclosed is the Detailed Claim Report generated by our Casualty Department which contains the claims and payment information we believe are associated with Mr. Tolen's accident. You will also find the Department's standard cover letter and information regarding requests for compromise.

Please review the claim record and make us aware of any claims which you do not believe are related to the accident, as well as any claims that you believe we should have received that are related to the accident.

The Casualty Department has assigned this file to Deborah Johnson and you may want to communicate with her directly. However, I will be glad to answer any questions you have related to Medicaid's Third Party Liability recovery efforts. You may reach me by telephone at 803.898.2793 or by email at carterbd@scdhhs.gov.

Sincerely,

Bruce D. Carter
Assistant General Counsel

Enc.

OFFICE OF GENERAL COUNSEL
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2795 • Fax (803) 255-8210

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

December 16, 2010

CERTIFIED MAIL

STANLEY MYERS ESQUIRE
MOORE, TAYLOR & THOMAS PA
PO BOX 5709
WEST COLUMBIA SC 29171-

Re: Keno L Tolen
Medicaid No.: 563 026 5660
Date of Accident: July 4, 2010

Dear Mr Myers:

You are hereby notified that Medicaid has paid for medical treatment resulting from sickness or injury for the above referenced recipient. Pursuant to S.C. Code Ann. Section 43-7-410 et.seq. 1976, as amended, the Department of Health & Human Services (DHHS) has subrogation and assignment rights from the client, to the extent of the amount(s) paid on his/her behalf by Medicaid. No settlement or apportionment should be made without our involvement. We should also be made aware of any settlement negotiations and if there is any court involvement in the case.

For cases in which the gross settlement proceeds are less than twice the amount of the Medicaid paid claims, the Department will determine what portion of the total recovery to claim based upon the attached cost effectiveness principles.

If Medicaid's expenditures have been determined, a summary of charges and Medicaid's payments which are or appear to be related to the above referenced accident will be attached. In the event DHHS is unable to provide this information at this time, you will be notified of the amounts paid by Medicaid when available. Please contact our office at (803) 898-2977 prior to final settlement negotiations to determine the current Medicaid claim amount.

When payment is made, a separate draft should be made payable to DHHS, and mailed to DHHS, Reporting and Receivables, P.O. Box 8297, Columbia, SC 29202-9189. **A copy of your final and signed disbursement sheet must accompany your check to the agency.**

Sincerely,

Deborah Johnson
Attachment(s)

Division of Third Party Liability
Casualty Department
PO Box 100127 Columbia, SC 29202-3127
Telephone (803) 898-2977 Fax (803) 255-8225

RPT5010 Paid Medicaid Claims Listing

REPORT DATE: December 16, 2010
Recipient Name: Keno L. Tolen
Medicaid ID Number: 5630265660
Dates of Accident/Illness: July 04, 2010

Provider Name	DOS From	DOS To	Billed	Paid
PAID CLAIMS TO DATE	07/04/10	07/21/10	117,849.91	29,741.13
MISC CLAIMS				
TOTAL MEDICAID EXPENDITURES:			117,849.91	29,741.13

********** NOTES **********

* MEDICAID'S CLAIM AMOUNT MAY NOT BE REDUCED WITHOUT PRIOR AUTHORIZATION FROM THIS OFFICE.

* NOTIFY THIS OFFICE IF CLIENT IS DECEASED.

* MEDICAID MUST BE NOTIFIED OF ANY AND ALL HEARINGS REGARDING OUR CLIENTS PRIOR TO THE HEARING/TRIAL DATE.

* MEDICAL PROVIDERS HAVE ONE YEAR FROM THE DATE OF SERVICE TO BILL MEDICAID. THEREFORE, OUR CLAIM AMOUNT MAY CHANGE DAILY AS ADDITIONAL CLAIMS ARE PAID. PLEASE CALL US PRIOR TO FINAL SETTLEMENT NEGOTIATIONS.

South Carolina Department of Health and Human Services
Detailed Claims Report

TOLEN, KENO L Medicaid ID: 5630265660 SSN: 591501687 DOB: 3/8/1987 County Elig: LEXINGTON Qual Cat: 30 AFDC Date of Accident: 07/04/2010

Claim Type Code	Provider Type Code	Provider Type	Provider Name	Billing Prov Name	Service Date	Last Svc Date	Days	Diag Code	Diag Desc	Proc Code	Procedure/Drug Name	Charge Submitted	Net Payme
A	20	Physician Individual	DAVID E KOON JR MD	UNIVERSITY SPECIALTY CLINI	07/05/10	07/05/10		81100	Fx Scapula NOS-Closed	23500	CLOSED TREAT CLAVICULAR FX W/O	$389.00	$7
A	20	Physician Individual	DAVID E KOON JR MD	UNIVERSITY SPECIALTY CLINI	07/05/10	07/05/10		81100	Fx Scapula NOS-Closed	23570	CLOSED TRT OF SCAPULAR FX W/O	$463.50	$15
A	20	Physician Individual	DAVID THOMAS FORD MD	PALMETTO HEALTH EMERGENCY	07/04/10	07/04/10		80121	Cl Skul Base Fx wo Coma	31500	INTUBATION ENDOTRACHEMERGENCY	$295.00	$8
A	20	Physician Individual	DAVID THOMAS FORD MD	PALMETTO HEALTH EMERGENCY	07/04/10	07/04/10		80121	Cl Skul Base Fx wo Coma	99285	E/M EMERGENCY DEPARTMENT SERV	$481.29	$14
A	20	Physician Individual	JAMES MORRISON	UNIVERSITY SPECIALTY CLINI	07/05/10	07/05/10		88100	Open Wound of Forearm	12034	LAYER CLOSURE(AREA) 7.6 CM TO	$392.00	$14
A	20	Physician Individual	LENWOOD P SMITH JR	UNIVERSITY SPECIALTY CLINI	07/04/10	07/04/10		85220	Traumatic Subdural Hem	99244	E/M CONSULT OFFICE CONSULT LEV	$420.00	$17
A	19	Medical Professional	LENWOOD P SMITH JR	UNIVERSITY SPECIALTY CLINI	07/04/10	07/04/10		85240	Traumatic Extradural Hem	61312	CRANIECTOMY-OTOMY HEMATOMA EXT	$7,325.00	$1,69
A	20	Physician Individual	MICHAEL STORM	PALMETTO RICHLAND	07/04/10	07/04/10		85246	Extradural Hem-Coma NOS	211	ANES FOR INTRACRANIAL PROCEDUR	$2,205.00	$16
A	20	Physician Individual	RAYMOND P BYNOE	UNIVERSITY SPECIALTY CLINI	07/04/10	07/04/10		85200	Traum Subarachnoid Hem	36580	REPLAC,NON-TUNEL CV CATH,W/O S	$1,021.00	$56
A	20	Physician Individual	RAYMOND P BYNOE	UNIVERSITY SPECIALTY CLINI	07/05/10	07/05/10		5185	Post Traum Pulm Insuffic	94003	VENT AST&MGMT,IP HOSP OBS,EA S	$164.00	$52
Z	01	Inpatient Hosp	PALMETTO RICHLAND	PALMETTO RICHLAND	07/06/10	07/06/10		85300	Traumatic Brain Hem NEC	99232	E/M IP SERV SUBSEQ HOSP CARE L	$100.00	$55
Z	02	Oupatient Hosp	PALMETTO RICHLAND	PALMETTO RICHLAND	07/04/10	07/08/10	4	85246	Extradural Hem-Coma NOS			$103,851.12	$26,85
					07/21/10	07/21/10		V5843	Aftercare Following Surg			$743.00	$7
Claim Count:													
12													
Total Paid:													
$29,741.13													
											Total Billed	$117,849.91	

INFORMATION NECESSARY TO CONSIDER COMPROMISE OF MEDICAID'S CLAIMS

1. Total amount of insurance offer;

2. Name of liable third party, insured and whether or not there will be additional funds forthcoming at a later date from other sources - PIP, Workman's Comp, Underinsured, Uninsured; Dram Shop, etc.;

3. Policy Limits;

4. The amount of outstanding medical bills to include name(s) of providers and the date(s) of service(s); (bills NOT PAID by S.C. Medicaid - we are not considered a medical provider).

5. Whether or not the medical providers will reduce their claims and to what extent;

6. Documentation of permanent impairment - copy of medical records, statements from attending physician;

7. Whether or not client has been released from medical treatment and the prognosis; what are the known future non-covered medical necessities and anticipated future medicals.

8. Whether or not you are reducing your fee to our mutual client and to what extent, specifically; amount of your direct and indirect costs;

9. Your offer to Medicaid;

10. Your proposed disbursement of the funds; describe how the recipient's portion of the settlement will be used, i.e., special needs trust for van, ramp, computer, etc.

Please allow a minimum of 10 days for our determination.

The client's Regional Medicaid Representative will be notified of any lump sum payments made to our client. This may affect his/her Medicaid eligibility. Eligibility questions should be directed to the client's caseworker at the client's Regional Medicaid Office.

Respond in writing to: Department of Health and Human Services (DHHS)
Division of Accountability and Collections
Post Office Box 100127
Columbia, South Carolina 2920-3127
Fax Number: 803 255-8225

09/03