DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Hess	7-20-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101040	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ C: Director Kelk Singleton cleared 8/4/11, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 7-29-11 [ ] 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.			
2.			
3.			
4.			

From: Bryan Kost
To: Jan Polatty
Date: 7/19/2011 6:30 PM
Subject: Please log - Fw: Fwd: Tonya K. Weathers--Medicaid Lien Inquiry (Forward from Info ID)
Attachments: Fwd: Tonya K. Weathers--Medicaid Lien Inquiry (Forward from Info ID)

From: "Edwin Wilson" <Edwin_wilson@knology.net>
To: <info@scdhhs.gov>
Date: 7/19/2011 6:13 PM
Subject: Tonya K. Weathers--Medicaid Lien Inquiry
Attachments: Medical Release_SC Dept of HHS.pdf

To Whom it May Concern:

Our office represents Tonya K. Weathers as a result of injuries she sustained due to a fall that occurred on July 30, 2010 in Columbia County, Georgia. We are writing to determine whether she has any outstanding liens with your office in connection with subsequent medical treatment she received in connection with the fall. Her personal information is as follows: Name: Tonya Kelly Weathers; DOB: January 11, 1963; SS#: XXX-XX-4026; Medicaid Member No.: 1780960777. We have attached a signed Authorization for release of health information for your convenience.

If there is anything else we can provide for you, please do not hesitate to contact us.

Very truly yours,

Edwin A. Wilson

Frails & Wilson

211 Pleasant Home Road

Suite A-1

Augusta, GA 30907

Office: 706.855.6715

Facsimile: 706.855.7631

S.C. Dept. of Health & Human Svcs
P.O. Box 8206
Columbia, SC 29202-8206

AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION
(Not For Research or Marketing Use)

Patient Name: Tonya Weather Social Security Number: ***-**-4026
Date of Birth: 1/11/63 Phone Number: 803-646-9976
Address: 2669 Pine Log Rd, Warrenville, SC 29851

I authorize S.C. Dept. of HHS, together with its employees, agents and contractor, to use or disclose the above names individual's protected health information (PHI) covered under the regulations pursuant to the health Insurance Portability and Accountability Act of 1996 concerning the period 7/30/10 to Present as described below.

☐ Discharge summary	☐ Laboratory Data	☐ Radiology Report
☐ Operative Report	☐ Pathology Report	☐ EKG
☐ Entire Medical Record	☒ Other (Narrative Report)	☒ Bills

I understand that PHI may include information protected under law, such as alcohol or drug abuse treatment information, mental health related communications or treatment information, or information regarding sexually transmitted diseases including HIV or AIDS testing opt treatment. I understand the PHI may include health information records of the patient disclosed to _____ by other health care providers. This authorization does not limit _____ ability to continue to use and disclose this health information in accordance with _____ Notice of Privacy Practices.

This information may be disclosed to the following individual or organization: Attorney Randolph Frails
Address: 211 Pleasant Home Road, Suite A-1, Augusta, Georgia 30907
Purpose: Reference Medical Records

I understand that I may revoke this authorization at any time by submitting a written revocation form provided by the facility to the Health Information Services department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an authorization date, event, or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment unless the provision of healthcare is for the purpose of creating PHI for disclosure to a third party (e.g. an employee physical exam). I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have any questions about disclosure of my health information, I can contact the Director Health Information Services or his/her designee.

I have read and understand this authorization and my questions have been answered. I certify that I am the Patient listed above or a person authorization to permit release of records on Patient's behalf. I hereby release _____ and its officers, trustees, employees, agents and contractors from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

Tonya K. Weather
Print Patient Name or Patient's Personal Representative Name

7/2/11
Date

X _____
Patient or Patient's Personal Representative Signature

_____
Basis of authority to sign for patient

Reg #0000440

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

August 4, 2011

EDWIN A WILSON ESQUIRE
FRAILS WILSON ATTORNEYS
211 PLEASANT HOME ROAD
SUITE A1
AUGUSTA GA 30907-

Re: Tonya K Weathers
Medicaid No.: 178 096 0777
Date of Accident: July 30, 2010

Dear Mr Wilson:

The attached summary of charges and Medicaid payments includes all claims paid by Medicaid, as of this date, which are or appear as if they could be related to the above referenced.

When payment is made, our separate draft, should be made payable to Department of Health and Human Services(DHHS), and mailed to DHHS, Reporting and Receivables, P.O. Box 8297, Columbia, SC 29202-9189.

Please contact our offce at (803) 898-2977 if more information is needed.

Sincerely,

Tasha Vaughn
Tasha Vaughn

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

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

August 4, 2011

CERTIFIED MAIL

J ARTHUR DAVIDSON ESQUIRE
P O BOX 1477
AUGUSTA GA 30903-1477

Policyholder: The Cincinnati Insurance Company
Policy Number:
Date of Loss: July 30, 2010
Claim Number:
Our Client: Tonya K Weathers

Dear Mr Davidson:

You are hereby notified, by certified mail, that the client referenced above was injured in an accident for which medical treatment was paid by Medicaid. Your firm holds the insurance on one of the parties. 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 paid on his/her behalf by Medicaid.

Neither the client, nor their legal representative, may release you from DHHS' subrogation or assignment claims. Therefore, when funds are disbursed, DHHS' **separate reimbursement draft** should be made payable directly to DHHS, and mailed to DHHS, Reporting and Receivables, P.O. BOX 8297, Columbia, SC 29202-9189. In the event DHHS enlists the assistance of our client's attorney, we will notify you, in writing, that it is unnecessary for you to pay us directly. However, if a claim is settled without DHHS' approval, DHHS will pursue an action against any liable third party.

If this claim has been settled prior to receipt of our notice, please provide this office with the date of settlement, names of any medical providers paid and amounts paid to them and the name of our client's attorney, if applicable.

Sincerely,

Tasha Vaughn

Tasha Vaughn

CONTACT PERSON:_____ TELEPHONE:_____

YOUR CLAIM NO.:_____ DATE:_____

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 Page 1

REPORT DATE: August 04, 2011
Recipient Name: Tonya K. Weathers
Medicaid ID Number: 1780960777
Dates of Accident/Illness: July 30, 2010

Provider Name	DOS From	DOS To	Billed	Paid
PAID CLAIMS TO DATE	07/30/10	08/04/11	22,314.09	2,770.01
MISC CLAIMS				
TOTAL MEDICAID EXPENDITURES:			22,314.09	2,770.01

********** 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

WEATHERS, TONYA K Medicaid ID: 1780960777 SSN: 249394026 DOB: 1/11/1963 County Elig: AIKEN Qual Cat: 30 AFDC Date of Accident: 07/30/2010

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 Payment
A	20	Physician Individual	DOUGLAS M WEDDLE MD	AIKEN EMERGENCY MEDICINE	07/30/10	07/30/10		9130	Abrasion Forearm	99284	E/M EMERGENCY DEPARTMENT SERV	$235.00	$94.55
A	20	Physician Individual	WILLIAM E DURRETT JR	AIKEN NEUROSCIENCES PC	08/16/10	08/16/10		7202	Sacroiliitis NEC	99212	E/M OFFICE/OP SERV EST PATIENT	$74.00	$27.82
A	20	Physician Individual	WILLIAM E DURRETT JR	AIKEN NEUROSCIENCES PC	09/02/10	09/02/10		7202	Sacroiliitis NEC	99213	E/M OFFICE/OP SERV EST PATIENT	$120.00	$48.03
A	20	Physician Individual	WILLIAM E DURRETT JR	AIKEN NEUROSCIENCES PC	09/28/10	09/28/10		7202	Sacroiliitis NEC	99213	E/M OFFICE/OP SERV EST PATIENT	$120.00	$48.03
A	20	Physician Individual	TY WILLIAM CARTER MD	CAROLINA MUSCULOSKELETAL I	08/16/10	08/16/10		92411	Contusion of Knee	99203	E/M OFFICE/OP SERV NEW PATIENT	$135.00	$72.28
A	20	Physician Individual	DAVID D GOLTRA JR	CAROLINA MUSCULOSKELETAL I	08/23/10	08/23/10		71946	Joint Pain-L/Leg	73721	MRI,JOINT LOWER EXTREM;W/O CON	$1,199.00	$323.51
A	20	Physician Individual	TY WILLIAM CARTER MD	CAROLINA MUSCULOSKELETAL I	08/24/10	08/24/10		72783	Plica Syndrome	99214	E/M OFFICE/OP SERV EST PATIENT	$118.00	$73.37
A	20	Physician Individual	TY WILLIAM CARTER MD	CAROLINA MUSCULOSKELETAL I	09/09/10	09/09/10		7172	Derang Post Med Meniscus	29881	ARTHROSCOPY KNE SURGI MENISC M	$3,181.00	$466.15
A	20	Physician Individual	TY WILLIAM CARTER MD	CAROLINA MUSCULOSKELETAL I	02/23/11	02/23/11		71516	Loc Prim Osteoart-L/Leg	99214	E/M OFFICE/OP SERV EST PATIENT	$118.00	$73.37
A	20	Physician Individual	TY WILLIAM CARTER MD	CAROLINA MUSCULOSKELETAL I	02/23/11	02/23/11		71516	Loc Prim Osteoart-L/Leg	20610	ARTHROCENTESIS MAJOR JT BURSA	$160.00	$55.26
A	20	Physician Individual	ROBERT FORD SEARLES	CAROLINA RADIOLOGICAL ASSO	07/30/10	07/30/10		7295	Pain in Limb	J1040	INJEC METHYLPREDNISOLONE ACETA	$19.00	$6.62
A	20	Physician Individual	ROBERT FORD SEARLES	CAROLINA RADIOLOGICAL ASSO	07/30/10	07/30/10		7295	Pain in Limb	73550	RADIOLOGIC EXAM FEMUR 2 VIEWS	$40.00	$7.10
A	20	Physician Individual	DALE GORDINEER	DOCTORS CARE SEVEN OAKS	08/05/10	08/05/10		92411	Contusion of Knee	72170	RADIOLOGIC EXAM PELVIS;1 OR 2	$40.00	$7.10
A	76	DME	HOME MEDICAL EQUIPMENT INC	HOME MEDICAL EQUIPMENT INC	09/10/10	09/10/10		71596	Osteoarthros NOS-L/Leg	99214	E/M OFFICE/OP SERV EST PATIENT	$132.00	$73.37
A	19	Medical Professional	ROBERT G OLDS	PALMETTO ANESTHESIA SERVIC	09/09/10	09/09/10		8360	Tear Med Menisc Knee-Cur	E0114	CRUTCH UNDRARM,NOT WOOD,ADJ/FX	$65.00	$41.60
A	22	Medical Clinics	THE SURGERY CENTER OF AIKE	THE SURGERY CENTER OF AIKE	09/09/10	09/09/10		7172	Derang Post Med Meniscus	1400	ANESTH, KNEE JOINT SURGERY, NO	$560.00	$107.80
A	22	Medical Clinics	THE SURGERY CENTER OF AIKE	THE SURGERY CENTER OF AIKE	09/09/10	09/09/10		7172	Derang Post Med Meniscus	29877	ARTHROSCOPY KNE SURGI DEBRID/S	$4,635.34	$206.85
A	22	Medical Clinics	THE SURGERY CENTER OF AIKE	THE SURGERY CENTER OF AIKE	09/09/10	09/09/10		7172	Derang Post Med Meniscus	29881	ARTHROSCOPY KNE SURGI MENISC M	$4,635.34	$411.70
D	70	Pharmacy	AIKEN DRUG COMPANY	AIKEN DRUG COMPANY	08/18/10					29875	ARTHROSCOPY KNEE SYNOVECT,LIMI	$4,635.34	$206.85
D	70	Pharmacy	AIKEN DRUG COMPANY	AIKEN DRUG COMPANY	09/09/10						OXYCODONE HCL 10 MG TABLET	$79.05	$68.55
D	70	Pharmacy	AIKEN DRUG COMPANY	AIKEN DRUG COMPANY	09/16/10						OXYCODONE-APAP 5-325 MG TAB	$14.91	$5.58
D	70	Pharmacy	AIKEN DRUG COMPANY	AIKEN DRUG COMPANY	09/16/10						OXYCODONE HCL 10 MG TABLET	$79.05	$68.55
D	70	Pharmacy	AIKEN DRUG COMPANY	AIKEN DRUG COMPANY	10/16/10						HYDROCODONE-APAP 10-500 TABLE	$64.78	$26.44
D	70	Pharmacy	AIKEN DRUG COMPANY	AIKEN DRUG COMPANY	10/16/10						OXYCODONE HCL 10 MG TABLET	$79.05	$68.55
D	70	Pharmacy	LANGLEY DRUG COMPANY	LANGLEY DRUG COMPANY	08/16/10						HYDROCODON-ACETAMINOPHN 10-50	$64.78	$26.44
D	70	Pharmacy	LANGLEY DRUG COMPANY	LANGLEY DRUG COMPANY	10/15/10						HYDROCODONE-APAP 10-500 TABLE	$61.75	$26.44
Z	02	Outpatient Hosp	AIKEN REG MED CENTERS INC	AIKEN REG MED CENTERS INC	07/30/10	07/30/10	0	9130	Abrasion Forearm		TRAMADOL HCL 50 MG TABLET	$45.70	$5.05
												$1,603.00	$123.05

Claim Count:
28
Total Charged Amount:
$22,314.09
Medicaid Total Paid:
$2,770.01