DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	9-26-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000165	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Wells Cleared 10/8/07 letter attached.	[X] Prepare reply for appropriate signature DATE DUE 10-5-07 [ ] 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.			

Meyer Center
FOR SPECIAL CHILDREN

September 25, 2007

Log: Myers
c: Wells
app. action

Mr. Robert M. Kerr, Director
S.C. Department of Health and Human Services
Medical Services
P.O. Box 8206
Columbia, SC 29202-8206

Dear Mr. Kerr:

Our Transportation Provider's Request for Payment Invoice for the month of July 2007 totaled $22,295.49. However, the payment received was only $19,110.42, which represents a difference of $3,185.07. Investigation revealed that this invoice was paid at the old 2006 reimbursement rate of $1.74 per passenger mile. Please note that our contract dated July 2007 indicates that our reimbursement rate is $2.03 per passenger mile. During a telephone conversation with Mr. Paul Barber on August 28, 2007, he explained that the rate most likely needed to be changed on the computer and indicated that an adjustment would be made and included with the reimbursement for August 2007.

Our Transportation Provider's Request for Payment Invoice for the month of August 2007 totaled $18,316.69. However, the payment received was only $15,700.02, which represents a difference of $2,616.67. As you can see, the invoice for August was again paid at the old 2006 reimbursement rate of $1.74 per passenger mile, and it did not include the $3,185.07 adjustment for July.

Upon receipt of this letter, please remit the balance due of $5,801.74 for the months of July and August 2007.

Thank you in advance for your time and prompt consideration of this matter. If you have any questions, please call me at (864) 250-0005, extension 204.

Sincerely,

Louise S. Anthony
Executive Director

Enclosures: *Remittance Advice for July 2007*
Remittance Advice for August 2007
Page 4 of July 2007 Contract

Stone Plaza • 1132 Rutherford Road • Greenville, SC 29609 • Tel. (864) 250-0005 • Fax (864) 250-0028
E-mail: meyers56@charter.net

amended). MCSC shall submit a reimbrusement request to SCDHHS for service provided the previous month in accordance with the Schedule of Reimbursement, which is published by SCDHHS.

See Appendix A, Schedule of Reimbursement and Appendix B, Transportation Provider's Request for Payment.

MCSC agrees to bill SCDHHS for the cost per mile to provide Non-Emergency Transportation Services. MCSC shall bill at a rate of two and 03/100 Dollars ($2.03) per passenger mile for transport of one (1) individual. MCSC agrees and understands that this rate is sufficient to cover the cost of any escort, attendant or other passenger that is required to accompany the Medicaid client.

MCSC agrees to make available to SCDHHS upon request documentation to support any and all transportation billed to and paid by SCDHHS. Failure to provide supporting documentation may result in recoupment of funds paid for the services for which documentation was requested. Medicaid Transportation Program Staff will complete DHHS Form 217 (Medicaid Transportation Invoice) for reimbursement.

MCSC shall also use the billing option of Electronic Data Interchange (EDI). The use of this billing method must meet all requirements of HIPAA (Health Insurance Portability and Accountability Act) as stipulated in Article X of this agreement.

MCSC agrees to bill for services by mailing a Transportation Provider's Request For Payment Invoice (Appendix B) to SCDHHS on a monthly basis. Invoices should be mailed to the following address:

South Carolina Department of Health and Human Services
Bureau of Rehabilitative and Medicaid Support Services
Division of Preventive and Ancillary Health Services
Medicaid Transportation Program
1801 Main Street, Suite 844
Post Office Box 8206
Columbia, South Carolina 29202

B. Non-Federal Share of Costs

The non-federal share of costs to receive FFP for provision of services under this contract is Ninety-eight Thousand, One Hundred Fifty-nine Dollars ($98,159).

As required by 45 CFR Part 201.5 and 42 CFR Part 433.45 (2004, as amended) any matching funds made available by MCSC must be in compliance with Public Law 102-234.

C. Method of Reimbursement

A passenger mile constitutes all allocated cost of transporting one (1) Medicaid eligible recipient one (1) mile. For reimbursement purposes, computations of passenger mileage begins at the pick-up and ends at the delivery point (i.e. from the recipient's home to the doctor's office).

PROVIDER ID. CT0042

000000675
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

TRANSPORTATION
REMITTANCE ADVICE

PAYMENT DATE: 08/24/2007

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER		SERVICE RENDERED DATE MMDDYY	CODE / MILES	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M / LAST NAME	TLE. 18 ALLOWED CHARGES	APPLIED TO DEDUCT.	TITLE 18 PAYMENT
	0722503248030600C			0	22295.49	19110.42	P	9999999999	NOT APPLICABLE		0.00	0.00
	01		070107	10,983	22295.49	19110.42	P			9110.42	0.00	0.00
	TOTALS		CLAIMS 1	0	22295.49	19110.42				9110.42	0.00	0.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

$0.00	CERT. PG TOT
$0.00	CERTIFIED AMT

$19,110.42	MEDICAID PG TOT
$19,110.42	MEDICAID TOTAL
$19,110.42	CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

5021733
CHECK NUMBER

PROVIDER NAME AND ADDRESS

MEYER CENTER FOR SPECIAL C
MEYER CENTER FOR SPECIAL C
1132 RUTHERFORD ROAD
GREENVILLE SC 29609

PROVIDER ID. CT0042

000000942
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

TRANSPORTATION
REMITTANCE ADVICE

PAYMENT DATE: 09/21/2007

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER		SERVICE RENDERED DATE MMDDYY	CODE MILES	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME	TLE. 18 ALLOWED CHARGES	APPLIED TO DEDUCT.	TITLE 18 PAYMENT
	07250047240314000			0	~~15700.02~~	15700.02	P	9999999999	NOT APPLICABLE		0.00	0.00
	01		080107	9,023	~~15700.02~~	15700.02	P			8316.69	0.00	0.00
	TOTALS		CLAIMS 1	0	~~15700.02~~ 18,316.69	15700.02				8316.69	0.00	0.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

$0.00	CERT. PG TOT
$0.00	CERTIFIED AMT

$15,700.02	MEDICAID PG TOT
$15,700.02	MEDICAID TOTAL
$15,700.02	CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

5039164 CHECK NUMBER

PROVIDER NAME AND ADDRESS

MEYER CENTER FOR SPECIAL C
MEYER CENTER FOR SPECIAL C
1132 RUTHERFORD ROAD
GREENVILLE SC 29609

#165

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 8, 2007

Ms. Louise S. Anthony
Executive Director
Meyer Center for Special Children
1132 Rutherford Road
Greenville, South Carolina 29609

Dear Ms. Anthony:

Thank you for your letter dated September 25, 2007, concerning the Meyer Center's State Fiscal Year (SFY) 2007-2008 Medicaid Transportation contract with the Department of Health and Human Services and the balance due the Meyer Center for the months of July and August 2007.

An adjustment, dated October 2, 2007, crediting the Meyer Center for $5,801.74 for the contract rate increase for the months of July and August 2007 has been submitted for payment. Occasionally, a rate increase will not be included in an invoice payment until one or two months after the beginning of the new contract year due to a delay in the signing process and the computer system rate change process that must follow the contract signing. Both of these processes are now complete for your transportation contract and your rate increase will be included in future SFY 07-08 contract payments.

We appreciate your continued support to the South Carolina Medicaid program. If you have any questions please call Mr. Paul Barber, Program Coordinator at (803) 898-2655.

Sincerely,

Emma Forkner

Emma Forkner
Director

EF/mhw

Office of the Director
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2504 Fax (803) 255-8235