

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR**

**ACTION REFERRAL**

TO <i>Hyers/FOIA</i>	DATE <i>1-11-08</i>
-------------------------	------------------------

<b>DIRECTOR'S USE ONLY</b>	<b>ACTION REQUESTED</b>
1. LOG NUMBER  <i>000351</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR  <i>CC: Singleton, Stanslaid Clausen 1/23/08 Attached. ✓</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____  <input checked="" type="checkbox"/> <i>FOIA</i> DATE DUE <i>1-28-08</i>
	<input type="checkbox"/> 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.			



**MEDICAL UNIVERSITY  
OF SOUTH CAROLINA**

University Medical Associates  
Compliance Department

150 Ashley Avenue  
PO Box 250583  
Charleston • SC 29425

Ph (843) 876-1321  
Fax (843) 876-1322

**RECEIVED**

JAN 11 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

SC Dept of Health and Human Services  
Bureau of Public Information  
P.O. Box 8206  
Columbia, SC 29202-8206

January 9, 2008

Good Morning,

The letter is a request for information under the FOIA (Freedom of Information Act). I would like to obtain the South Carolina Medicaid procedure code utilization broken down by specialty and code. The specific codes I am interested in are the Evaluation and Management codes 99201-99215, 99221-99233, 99241-99255, 99281-99285. Attached is a one-page example of what I need. I am interested in the calendar year 2007, but if that is not available then calendar year 2006 would be fine. These codes will be used for statistical analysis. Please send the information to my attention to the address above. If there are any questions or problems, I can be reached at (843) 876-1323 or at [collinsu@musc.edu](mailto:collinsu@musc.edu). Thank you for your assistance.

Sincerely,

Suzanne Collins, RHIA, CPC, EMS  
Corporate Compliance Manager

Log 000351

UMA COMPLIANCE DEPARTMENT

150 ASHLEY AVE, ROOM 401

CHARLESTON, SC 29425

843-876-1321

FACSIMILE TRANSMITTAL SHEET

TO: Nancy Robert FROM: Suzanne Collins  
 COMPANY: SC DHHS DATE: 1-14-08  
 FAX NUMBER: 1-803-255-8353 TOTAL NO. OF PAGES INCLUDING COVER: 2  
 PHONE NUMBER:

RE: Sample of what I need

- URGENT
- FOR REVIEW
- PLEASE COMMENT
- PLEASE REPLY
- PLEASE RECYCLE

NOTES/COMMENTS:

*I do need this data for All Services  
 for codes 99201-99285 for ~~XXXX~~  
 1/1/07-12/31/07.  
 Thanks.*

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure. If the reader of this message is not the intended recipient or an employee responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail. Thanks.

*Brenda -  
 add to the  
 log - missing  
 part*

CLICK HERE AND TYPE RETURN ADDRESS:

Totals for Procedure Code Range: 99201 - 99215  
 Paid Dates 01/01/2003 - 12/31/2003

<u>Spec</u>	<u>Proc Code</u>	<u>Units</u>	<u>Amount Paid</u>	
02 ALLERGY AND IMMUNOLOGY	99201	5	\$150.00	
	99202	14	\$565.09	
	99203	117	\$6,950.06	
	99204	729	\$61,883.59	
	99205	169	\$18,353.93	
	99211	12,822	\$172,449.39	
	99212	784	\$19,577.42	
	99213	7,636	\$251,839.11	
	99214	2,734	\$143,018.39	
	99215	171	\$11,288.52	
		25,181	\$686,075.50	
	03 ANESTHESIOLOGY	99201	16	\$453.74
		99202	63	\$2,568.42
		99203	240	\$9,505.36
		99204	248	\$17,060.89
99205		65	\$4,718.07	
99211		240	\$2,246.30	
99212		838	\$18,704.01	
99213		2,386	\$60,088.71	
99214		637	\$26,429.42	
99215		41	\$1,749.42	
		4,774	\$143,524.34	
05 CARDIOVASCULAR DISEASES		99201	8	\$189.01
		99202	29	\$1,181.23
		99203	121	\$6,717.84
		99204	229	\$19,071.90
	99205	73	\$7,735.02	
	99211	1,463	\$18,792.37	
	99212	1,637	\$39,666.58	
	99213	6,490	\$207,934.20	
	99214	3,873	\$190,697.69	
	99215	173	\$12,706.49	
		14,096	\$504,692.33	
	05 CARDIOVASCULAR DISEASES	99201	22	\$660.00
		99202	204	\$9,651.00
		99203	1,000	\$64,621.83
		99204	195	\$17,652.21

Source: Medicaid Paid Claims Database  
 Prepared By: Kevin Rogers, Bureau of Program Support

Page: - 1 -  
 Date: 05/21/04

This report does not reflect any agency financial adjustments made outside of MMIS.

Filename: G:\USERS\ROGERS\ARIES\src\Ranges.tkr



**State of South Carolina**  
**Department of Health and Human Services**

Mark Sanford  
Governor

Erma Forkner  
Director

TO:  
FROM:

SUBJECT: Cost of Processing Request for Information

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:	_____	\$ _____
<b>Total Amount Due SCDHHS:</b>		<b>\$ _____</b>

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: \_\_\_\_\_



*State of South Carolina*  
*Department of Health and Human Services*

Mark Sanford  
Governor

January 23, 2008

Emma Fortner  
Director

Suzanne Collins, RHIA, CPC, EMS  
Corporate Compliance Manager  
Medical University of South Carolina  
150 Ashley Avenue  
Post Office Box 250583  
Charleston, South Carolina 29425

Dear Ms. Collins:

Thank you for your FOIA request regarding procedure code utilization of specific Evaluation and Management codes. I have enclosed a CD containing the data broken down by specialty per your request.

If you should need additional information, please contact Mr. Will Feagin, Team Leader in Physician Services, at 803-898-3040. We appreciate your continued support and participation in the South Carolina Medicaid Program.

Sincerely,

A handwritten signature in black ink that reads "BZ Giese".

Melanie "BZ" Giese, RN  
Bureau Director, Health Services

MG\wd

# 351





State of South Carolina  
Department of Health and Human Services

Mark Sanford  
Governor

Emma Fortner  
Director

TO:  
FROM:

SUBJECT: Cost of Processing Request for Information

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	<u>5</u> Hours	\$ <u>50.00</u>
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:	_____	\$ _____
<b>Total Amount Due SCDHHS:</b>		<b>\$ <u>50.00</u></b>

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 Will Feagin should you have any questions.

788 5040

1/23/18  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**SOUTH CAROLINA  
STATE HEALTH AND HUMAN SERVICES  
FINANCE COMMISSION**

**ACCOUNTS RECEIVABLE CERTIFICATION**

**RECEIVABLE NUMBER:**

**GENERAL INFORMATION**

**CERTIFICATION ACTION:**

NEW     CHANGE

**DEBT CLASSIFICATION:**

FRAUD     NON-FRAUD

**NAME OF DEBTOR:**

Suzanne Collins, RHIA, CPC, EMS  
Corporate Compliance Manager  
Medical University of South Carolina

**COUNTY NAME:**

**ADDRESS OF DEBTOR:** 150 Ashley Avenue

Post Office Box 250583  
Charleston, SC 29425

**COUNTY NUMBER:**

**PROVIDER ID NUMBER OR FAMILY CASE NUMBER:**

**PERIOD OF OVERPAYMENT**

**FROM:**

**TO:**

**PROGRAM INVOLVED:**

**TYPE SERVICE:**

FOIA - Log 000351

**AMOUNT DUE:**

\$50.00

**DATE DUE:**

**FUNDING INFORMATION**

AMOUNT	COST CENTER	AMOUNT	COST CENTER
STATE \$ _____		DONOR \$ _____	
FEDERAL \$ _____		PROVIDER \$ _____	
COUNTY \$ _____		OTHER \$ _____	
		PENALTY \$ _____	

**PAYMENT INFORMATION**

**REPAYMENT TERMS**

**TERMS GRANTED (Months):**

**INTEREST RATE:**

DEDUCT     DO NOT DEDUCT

**NOTES - LIST OF ATTACHMENTS**

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**REQUESTER'S SIGNATURE:**

Nancy Rabert *Nancy Rabert*

**TITLE:**

Administrative Assistant  
Bureau of Health Services

**COUNTY/DIVISION:**

**DATE:**

1/28/08

**AUTHORIZER'S SIGNATURE:**

Melanie Giese *Melanie Giese*

**TITLE:**

Bureau Director  
Bureau of Health Services

**COUNTY/DIVISION:**

**DATE:**

1/28/08