DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	7-30-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 090058	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Kat Cleared 8/6/09 letter attached	[X] Prepare reply for appropriate signature DATE DUE 8-6-09 [ ] 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.			

I think this should go to Felicity's staff however we may want to refer him to GAPS. I looked in MEDS and there are many Robert Smith's.

AJ

WILLIAM H. "BILLY" O'DELL
SOUTH CAROLINA STATE SENATE
DISTRICT 4, ABBEVILLE AND ANDERSON COUNTIES
610 GRESSETTE SENATE OFFICE BUILDING
COLUMBIA, SOUTH CAROLINA 29202
803-212-6040
E-MAIL: WHO@SCSENATE.ORG

COMMITTEES
Agency Heads Salary Commission
Banking and Insurance
Finance
General
Invitations
Joint Bond Review
Labor, Commerce and Industry

HOME ADDRESS:
Box 540
Ware Shoals, SC 29692
(864) 861-2222
Toll Free 1-800-342-2843
E-mail: billy@odellcorp.com

July 29, 2009

Ms. Emma Forkner
Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202

Dear Emma:

I am enclosing a copy of a letter that I received from Marlene Hanks regarding the problem her father, Robert Smith, is having with his Medicare Part D prescription drug coverage. I believe that you will find her correspondence to be self-explanatory.

Emma, could you please have a member of your staff look into this request for me? I am sure Ms. Hanks would welcome any suggestions, guidance or assistance that you can offer. As always, I appreciate your continued assistance with my many requests, and it is certainly a pleasure to work with Byran Kost. He is always very helpful to me and my staff.

Thank you for your attention to this matter, and if I can ever assist you in any way, please feel free to contact me.

Sincerely,

Billy

William H. "Billy" O'Dell
South Carolina State Senator

WHO/klm
Enclosure
cc: Marlene Hanks

July 20, 2009

The Honorable William H. O'Dell
PO Box 540
Ware Shoals, SC 29692

Dear Senator O'Dell:

I talked with you some time ago regarding a problem my father was having with his Medicare Part D prescription drug coverage, it is with Community CCRx. They paid over $2,000 to a mail order drug company for my dad's respiratory medication and it is my understanding that they should not have paid that claim, it should have been submitted directly to Medicare, not his drug plan. Because of this claim it put may dad in what they call the doughnut hole and he has to pay the full price for his medication. I am attaching copies of his drug bills just from February until June just to show what he has had to pay out-of-pocket. His home health care nurse checked into this and she believes that Community CCRx made an error in what they paid because they said the claim was for injection medication and my father's medication is for inhalation. The mail order company is Pharmacy South 8528 Highway 31, Calera, AL 35040, their telephone number is (888) 879-6684.

We would appreciate any help you could give us in this matter.

Yours truly,

Marlene Hanks

Marlene Hanks

M E D I C A L E X P E N S E S DSN DTE:05/19/2002 END DTE:05/19/2009

FOR: SMITH, ROBERT
CARE OF: PO BOX 214
218 PARK DRIVE
SMITHS IVR SC029535

DIXON-POWERS DRUG CO.
625 NORTH MAIN
ANDERSON, S.C. 29621
PHARMACIST - FORT, JIM

02/05/09	06136864	DIGOXIN .25MG(LANN	30	TAB	SOFLEY	.00	COPAY
02/05/09	06138821	PREDNISONE 20(WATS	50	TAB	SOFLEY	.00	COPAY
02/12/09	06139391	WARFARIN 2.5MG(BAR	45	TAB	SOFLEY	.00	COPAY
02/23/09	06138822	POTASSIUM CL 20MEQ	30	TAB	SOFLEY	.00	COPAY
02/23/09	06141277	LISINOPRIL 10MG(MY	30	TAB	SOFLEY	.00	COPAY
02/23/09	06140747	HUMALOG INSULIN	10	ML	SOFLEY	25.13	COPAY
03/04/09	06142342	QUININE SULFATE 26	30	TAB	SOFLEY	15.00	Rx
03/10/09	06136084	DIGOXIN .25MG(LANN	30	TAB	SOFLEY	.00	COPAY
03/10/09	06141276	SERTRALINE HCL 50	30	TAB	SOFLEY	.00	COPAY
03/10/09	06139253	METOPROLOL 50MG(CO	60	TAB	SOFLEY	.00	COPAY
03/11/09	06140747	HUMALOG INSULIN	10	ML	SOFLEY	25.13	COPAY
03/13/09	06136832	LANTUS 100 UNITS/M	10	ML	SOFLEY	65.20	COPAY
03/19/09	04032579	HYDROCOD/APAP 5/50	120	TAB	SOFLEY	13.32	COPAY
03/22/09	06136081	WARFARIN 2.5MG(BAR	45	TAB	SOFLEY	13.91	COPAY
03/27/09	06138821	PREDNISONE 20(WATS	50	TAB	SOFLEY	7.60	COPAY
03/27/09	06141277	LISINOPRIL 10MG(MY	30	TAB	SOFLEY	8.44	COPAY
03/27/09	06142507	FUROSEMIDE 40MG(QU	60	TAB	SOFLEY	7.56	COPAY
03/27/09	06138822	POTASSIUM CL 20MEQ	30	TAB	SOFLEY	9.80	COPAY
03/27/09	06140747	HUMALOG INSULIN	10	ML	SOFLEY	100.50	COPAY
04/09/09	06136084	DIGOXIN .25MG(LANN	30	TAB	SOFLEY	7.32	COPAY
04/09/09	06141276	SERTRALINE HCL 50	30	TAB	SOFLEY	11.64	COPAY
04/09/09	06143193	DOXYCYCLINE 100 MG	14	CAP	BATIZY	5.23	COPAY
04/13/09	06143233	HUMALOG INSULIN	30	ML	SOFLEY	297.49	COPAY
04/25/09	06141277	LISINOPRIL 10MG(MY	30	TAB	SOFLEY	8.44	COPAY
05/04/09	06138232	LANTUS 100 UNITS/M	10	ML	SOFLEY	93.34	COPAY
05/04/09	06138822	POTASSIUM CL 20MEQ	30	TAB	SOFLEY	9.80	COPAY
05/12/09	06141276	SERTRALINE HCL 50	30	TAB	SOFLEY	11.64	COPAY
05/12/09	06139253	METOPROLOL 50MG(CO	60	TAB	SOFLEY	8.52	COPAY
05/12/09	06136084	DIGOXIN .25MG(LANN	30	TAB	SOFLEY	7.70	COPAY
05/20/09	06138821	PREDNISONE 20(WATS	60	TAB	SOFLEY	7.60	COPAY
05/20/09	06136081	WARFARIN 2.5MG(BAR	45	TAB	SOFLEY	13.91	COPAY
05/29/09	06141277	LISINOPRIL 10MG(MY	32	TAB	SOFLEY	8.44	COPAY
05/29/09	06143233	HUMALOG INSULIN	10	ML	SOFLEY	100.50	COPAY
06/17/09	06143233	HUMALOG INSULIN	10	ML	SOFLEY	100.50	COPAY
06/17/09	06139304	VITAMIN D 50000IU	4	CAP	SOFLEY	12.00	Rx
06/17/09	06140907	FUROSEMIDE 40MG(QU	60	TAB	SOFLEY	7.56	COPAY
06/17/09	04031672	LORAZEPAM 1MG(WATS	120	TAB	SOFLEY	60.00	Rx
06/17/09	06141276	SERTRALINE HCL 50	30	TAB	SOFLEY	11.64	COPAY
06/17/09	06139304	POTASSIUM CL 20MEQ	30	TAB	SOFLEY	9.80	COPAY
06/17/09	06136984	DIGOXIN .25MG(LANN	32	TAB	SOFLEY	7.73	COPAY

1091.42 TOTAL

Community CCRx
P.O. Box 5203
Rensselaer, NY 12144-5203

www.communityccrx.com

EOB

Community CCRx℠

Local Pharmacists Caring for You.

00087583-396

00087583 01 AV 0.324
ROBERT SMITH
PO BOX 314
IVA SC 29655-0314

04/06/2009
Member ID Number: 9689614864
Rx Group Number: COMCCRX

Explanation of Benefits(EOB) for Your Medicare Prescription Drug Coverage (Part D)
THIS IS NOT A BILL Keep this notice for your records.

This notice includes:

1. How much you've paid so far this year for your prescriptions
2. Your recent claims for prescriptions

1. **Summary of Your Year-to-Date Medicare Prescription Drug Costs**
Definitions of the terms used are provided on the next page of this document.

	Plan Deductible:	Total CCRx paid:	Total you/others on your behalf paid:	Total that you / others on your behalf paid that **counted** toward your out-of-pocket costs:	Total that you / others on your behalf paid that **didn't count** toward your out-of-pocket costs:	Total Drug Costs left to move to the initial coverage period:
1. Yearly Deductible	$295.00	$0.00	$287.45	$287.45	$0.00	$0.00
2.Initial Coverage Period	Maximum you/plan/ others pay in this period $2,700.00	Total CCRx paid: $2,329.90	Total you/others on your behalf paid: $82.65	Total that you / others on your behalf paid that **counted** toward your out-of-pocket costs: $82.65	Total that you / others on your behalf paid that **didn't count** toward your out-of-pocket costs: $0.00	Total Drug Costs left before the coverage gap: $0.00
YOUR CURRENT COVERAGE PERIOD **3. Coverage Gap**	Maximum you/others on your behalf pay in this period: $4,350.00	Total CCRx paid: $0.00	Total you/others on your behalf paid: $218.35	Total that you / others on your behalf paid that **counted** toward your out-of-pocket costs: $218.35	Total that you / others on your behalf paid that **didn't count** toward your out-of-pocket costs: $0.00	Amount left before catastrophic coverage: $3,761.55
4. Catastrophic Coverage	No Maximum	Total CCRx paid: $0.00	Total you/others on your behalf paid: $0.00			

Out-of-Pocket Costs to Date: $588.45

Yearly Deductible - The amount of total drug costs, $295.00, you and/or all others making payments on your behalf must pay before CCRx begins to pay for covered drugs.

Initial Coverage Period - The initial coverage period begins after you meet the yearly deductible.

You generally pay a copayment/coinsurance for each prescription during this period. The initial coverage period ends when your total drug costs reach the initial coverage limit of $2,700.00 during the coverage year.

Coverage Gap - This is the period after the initial coverage period and before catastrophic coverage during which you and/or all others making payments on your behalf are responsible for all of your drug costs.
CCRx doesn't cover any drug costs during this coverage period.

This period ends when you or certain others making payments on your behalf spend $4,350.00 in out-of-pocket costs.

Out-of-Pocket Costs - Includes payments that you and/or certain others on your behalf paid for covered drugs during the coverage year. This includes payments made in the deductible, initial coverage period, and/or coverage gap this coverage year. Payments made by certain others that count toward your out-of-pocket costs include those made by family members, State Pharmaceutical Assistance Programs (SPAPs), and most charities. This amount does not include amounts paid by CCRx or certain others making payments on your behalf.

Payments made by certain others that don't count toward your out-of-pocket costs include those made by group health plans (like from a current or former employer or union), other insurance, or government-funded health programs.

Once your out-of-pocket costs reach $4,350.00, you move into the catastrophic coverage period.

Catastrophic Coverage - This period begins once your out-of-pocket drug costs reach $4,350.00.

This is the period where you pay 5% with a $6.00 minimum for brand-name drugs, 5% with a $2.40 minimum for generics at retail for your covered drugs for the remainder of the coverage year.

Total Drug Costs - This is the total amount spent on your covered drugs this coverage year by CCRx, you, and/or all others making payments on your behalf during all coverage periods.

2. **Summary of Prescription Claims Processed from** 03/01/2009 **through** 03/31/2009

Member ID Number: 9689614864

Date rescription Filled	Prescription Claim Number	Name of Drug	Quantity Filled	Amount CCRx Paid	Amount You Paid	Amount Paid by Secondary Coverage/Other Sources	Extra Help from Medicare
3/10/2009	6136884	DIGOXIN	30	6.75	0.00	0.00	0.00
3/10/2009	6141276	SERTRALINE HCL	30	11.64	0.00	0.00	0.00
3/10/2009	6139253	METOPROLOL TARTRATE	60	6.53	0.00	0.00	0.00
3/11/2009	6140747	HUMALOG	10	75.37	25.13	0.00	0.00
3/13/2009	6138232	LANTUS	10	27.14	66.20	0.00	0.00
3/19/2009	4082579	HYDROCODONE-ACETAMINOP	120	0.00	13.39	0.00	0.00
3/23/2009	6136081	WARFARIN SODIUM	45	0.00	13.91	0.00	0.00
3/27/2009	6141277	LISINOPRIL	30	0.00	8.44	0.00	0.00
3/27/2009	6138822	POTASSIUM CHLORIDE	30	0.00	9.80	0.00	0.00
3/27/2009	6140807	FUROSEMIDE	60	0.00	7.56	0.00	0.00
3/27/2009	6138821	PREDNISONE	60	0.00	7.60	0.00	0.00
3/27/2009	6140747	HUMALOG	10	0.00	100.50	0.00	0.00

otals

Totals Drug Cost From 03/01/2009 **to** 03/31/2009 **:** $379.96
Out-of-Pocket costs: $252.53
Amount you Paid: $252.53
Total amount left to pay before catastrophic coverage: $3,761.55

The amount listed in "Amount Paid by Secondary Coverage/Other Sources" includes payments made by all sources other than yourself or extra help from Medicare. Amounts paid on your behalf that do not count toward your out-of-pocket costs described in section 1 include those made by group health plans (like from a current or former employers or union), other insurance, or Government-funded health programs. Amounts paid on your behalf that do count toward your out-of-pocket costs include those made by family members, Medicare's extra help, State Pharmaceutical Assistance Programs (SPAPs), and most charities.

What to do if you have any questions.

If you have questions, please call toll-free 1-866-684-5353 8:00 a.m. to 8:00 p.m. or, visit www.communityccrx.com on the web. TTY users should call 1-866-684-5351.

Para obtener una copia de esta información en español, llame GRATIS al 1-866-684-5353. Los usuarios de TTY deben llamar al 1-866-684-5351.

What to do if you disagree with the accuracy of this Explanation of Benefits.

If you have a question or complaint about any information contained here we encourage you to contact us at the number shown. If still dissatisfied you have the right to file a grievance with us. Grievances should be sent to us at P.O. Box 5205 Rensselaer, NY 12144-5205.

What to do if you disagree with a Medicare Drug Plan's coverage decision.

If we deny your request for a drug you haven't received, or deny your request to pay you back for a drug you have received, we will send you a letter explaining our decision . If you disagree with our decision, you can request an appeal within 60 calendar days from the date of our first decision. You can request a standard or fast (expedited) appeal. We will automatically give you a fast appeal if your physician tells us that your life or health may be seriously jeopardized by waiting for a standard decision. You can request an appeal by:

Writing a letter to P.O. Box 391197, Solon, OH 44139
Calling 1-866-316-6049
Sending a fax to 1-866-868-0858

Your doctor needs to give us a statement explaining that the drug you need is medically necessary to treat your condition if you or your doctor believe:

You need a drug that isn't on our list of covered drugs (formulary),
The plan should waive a coverage rule or limit on a drug you need, or
You can't take any of the drugs on our preferred tier for your condition, and you would like us to cover a non-preferred drug at the preferred cost-sharing amount.

Your doctor needs to give us a statement by sending it to P.O. Box 391197, Solon, OH 44139, fax number 1-866-868-0858 or calling us at 1-866-316-6049.

Suspect fraud?

If you suspect fraud, please contact Community CCRx P.O. Box 5205 Rensselaer, NY 12144-5205, 1-866-684-5353. Or, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

Do you have limited income and resources?

You may qualify for extra help paying your Medicare prescription drug costs. For more information about applying for extra help, visit www.socialsecurity.gov on the web or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Member ID Number: 9689614864

Log #0058

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

August 6, 2009

Robert Smith
P.O. Box 314
Iva, SC 29655

Dear Mr. Smith

Senator William H. "Billy" O'Dell contacted our agency in response to the letter that your daughter, Ms. Marlene Hanks, wrote on your behalf regarding the difficulties you are having with your Part D prescription Drug coverage.

Medicare administers the Part D prescription Drug plans. In an effort to be of assistance, a member of Pharmacy Services at the South Carolina Department of Health and Human Services (SCDHHS) has been in direct contact with the Medicare plan, Community CCRx, and the mail order pharmacy in Alabama to make them aware of the problems that you have been having facing. Community CCRx has committed to work with you to resolve your issues.

You are currently enrolled in the South Carolina Gap Assistance Pharmacy Program for Seniors (GAPS) which provides state pharmacy assistance to supplement the drug coverage available through a Medicare prescription drug plan. The South Carolina Department of Health and Human Services (SCDHHS) administers the GAPS program. If you have any questions about the GAPS program, please contact your GAPS worker, Timothy Cozine, in Central Eligibility Processing, at (803) 898-4881.

We have enclosed information on other programs and organizations that can assist residents in South Carolina with their healthcare needs, prescriptions and daily living expenses. If you have questions about the Medicaid program, please contact Jennifer Lynch in Constituent Services at (803) 898-3965. I hope this information is helpful.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Deputy Director

AJ/lp

Enclosures

Medicaid Eligibility and Beneficiary Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
Phone (803) 898-2502 • Fax (803) 255-8235

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

August 6, 2009

The Honorable William H. "Billy" O'Dell
South Carolina Senate
610 Gressette Senate Office Building
Columbia, South Carolina 29202-0142

Dear Senator O'Dell:

Thank you for referring Ms. Marlene Hanks to our agency regarding the difficulties her father, Robert Smith, is having with his Part D prescription Drug coverage.

Medicare administers the Part D prescription Drug plans, but a member of my staff has been in direct contact with the Medicare plan, Community CCRx, and the mail order pharmacy in Alabama to make them aware of the problems Mr. Smith is facing. Community CCRx is working to resolve the issues that Mr. Smith is facing. We have also sent Mr. Smith information on other programs that can assist South Carolina residents with their healthcare needs, prescriptions and daily living expenses.

Thank you for your continued interest and support of the South Carolina Medicaid program. If I may be of further assistance on this or any other matter, please let me know.

Sincerely,

Emma Forkner
Director

EF/mgbd