

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
<i>Supra/Mancy</i>	<i>6-19-12</i>

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER	<i>100486</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	
2. DATE SIGNED BY DIRECTOR	_____	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>ASAP</i> _____ <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action	
<i>* Two separate letters</i> <i>cc: Mr. Treck, Singleton, Walberg</i>			

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. <i>Cleared 6/22/12, letter attached.</i>			
2.			
3.			
4.			



AVALONIA GROUP HOMES, INC.

RECEIVED

JUN 15 2012

Department of Health & Human Services
OFFICE OF THE DIRECTOR

June 13, 2012

Mr. Anthony Keck
Director
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

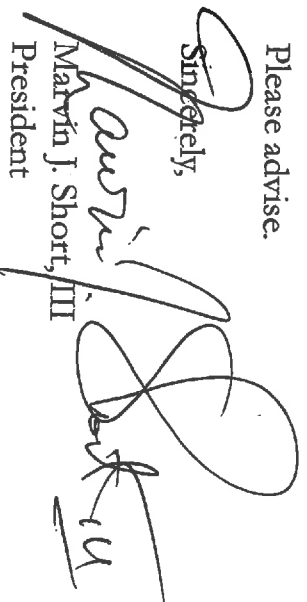
Re: Remittance Advice dated 06/15/2012

Dear Director Keck:

I wanted to bring your attention to the Remittance Advice for our Hampton location. We should have received funds in the amount of \$28,227.00, but report is showing we will be receiving \$376,554.00. This will result in an overpayment of \$348,327.00, if it is paid Friday, June 15, 2012.

Please advise.

Sincerely,


Marvin J. Short, III
President

Enclosure

PO Box 968
Travelers Rest, SC 29690
Phone (864)836-7220

HAMPTON PSYCHIATRIC RESIDE
HAMPTON PRIT
PO BOX 1214
PICKENS
, SC 29671-1214

ATTENTION 000088195
EFFECTIVE JULY 1, 2012, CLAIMS OR SERVICES THAT REQUIRE PRIOR AUTHORIZATION FROM THE QIO (KEPRO) WILL AUTOMATICALLY REJECT IF THE
AUTHORIZATION NUMBER IS NOT PRESENT ON THE CLAIM OR IS INVALID. PLEASE REFER TO THE MEDICAID BULLETIN DATED APRIL 11, 2012 FOR A
COMPLETE LIST OF SERVICES THAT REQUIRE PRIOR AUTHORIZATION FROM KEPRO.

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MDDY-MMDY	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T ID. NUMBER	RECIPIENT NAME I M LAST NAME	CO PY DRG TYPE XOV
00118	1216000612440300Z	060112-0607	7	2,037.00	P	J MANUEL	998-0 G
00146	1216000613440300Z	060112-0607	7	2,037.00	P	I C REVIS	998-0 G
00149	1216000614440300Z	060112-0607	7	2,037.00	P	J S OGLESBY	998-0 G
00147	1216000615440300Z	060112-0607	7	2,037.00	P	A Z MCABEE	998-0 G
00103	1216000616440300Z	060112-0607	7	2,037.00	P	M T HOLDER	998-0 G
00138	1216000617440300Z	060112-0607	7	2,037.00	P	J S HANNON	998-0 G
00149	1216000618440300Z	060112-0607	7	2,037.00	P	E M GILLIAM	998-0 G
00137	1216000619440300Z	060112-0607	7	2,037.00	P	B J LONG	998-0 G
00144	1216000620440300Z	060112-0607	7	2,037.00	P	J METCALF	998-0 G
00148	1216000621440300Z	060112-0607	7	2,037.00	P	T J ROONEY	998-0 G
00150	1216000622440300Z	060112-0607	7	2,037.00	P	B M PROCTOR	998-0 G
00135	1216000623440300Z	060112-0601	1	291.00	R	J J MARKS	998-0 G
00106	1216000624440300Z	060112-0607	7	2,037.00	P	C J AIKEN	998-0 G
00167	1216000625440300Z	060112-0607	7	2,037.00	P	D DICKARD	998-0 G
00135	1216000626440300Z	060312-0607	5	1,455.00	R	J J MARKS	998-0 G
TOTALS			15	28,227.00			
CLAIMS			15	376,554.00			

SCHAP PG TOT	\$0.00	MEDICAID PG TOT	\$376,554.00
SCHAP TOTAL	\$0.00	MEDICAID TOTAL	\$376,554.00
* CHECK TOTAL	\$376,554.00	* CHECK TOTAL	\$376,554.00
P = PAYMENT MADE		R = REJECTED	
S = IN PROCESS		CHECK NUMBER	6991368
PROVIDER NAME AND ADDRESS	HAMPTON PSYCHIATRIC RESIDE HAMPTON PRTE PO BOX 1214 PICKENS SC 29671		

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.

* FUNDS AUTOMATICALLY DEPOSITED TO:
 BANK NAME: BRANCH BANK & TRUST COMPA ACCOUNT #: XXXXXXXXXX9943
 NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

ORIGINAL CGN:
ADJ CGN:

INSURANCE EDITS
CLAIM EDITS
000-553 000-951

** AGENCY USE ONLY
** APPROVED EDITS

! CLAIMS/LINE PAYMENT INFO !
! EDIT PAYMENT DATE !
! !

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
INPATIENT/OUTPATIENT - 01
DOC IND

RUN DATE 06/12/2012 000088197
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID

RECIP NAME JACOB J MARKS

NPI: 1508017476 TAXONOMY: 323P00000X PRV ZIP: 29690-0968
51) RTF031 3) 00135 4) 113 6) 06/01/12 06/01/12 7) 24) C5 25) 26) 27) 28) 29) 30)
32A) 42 06/01/12 33A) / / / 34A) / / 35A) / / 36A) / / 37) 38) 39) 40) 41) 42) 43) 44) 45) 46) 47) 48) 49) 50) 51) 52) 53) 54) 55) 56) 57) 58) 59) 60) 61) 62) 63) 64) 65) 66) 67) 68) 69) 70) 71) 72) 73) 74) 75) 76) 77) 78) 79) 80) 81) 82) 83) 84) 85) 86) 87) 88) 89) 90) 91) 92) 93) 94) 95) 96) 97) 98) 99) 100)

39A) 01 291.00 40A) 40B) 40C) 40D) 41A) 41B) 41C) 41D)

MEDICAID CARRIER ID 619
1ST OTHER PAYER 50)
2ND OTHER PAYER 50)

54P) 63) PP39062 DRG REIMBURSEMENT A 60)

(67) 314.01 (68) (69) (70) (71) (72) (73) (74) (75) (76) 314.01 82) 1508017476 83A) 83B) 0.00 (48) 0.00 (NDC)
RES LN 001 120 (42) (44) (45) (46) 0001 (47) 291.00 291.00
TOTAL CHARGES 001

INSURANCE POLICY INFORMATION

RESOLUTION DECISION
RETURN TO: MEDICAID CLAIMS RECEIPT, P.O. BOX 1458, COLUMBIA, SC 29202-1458
PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
INPATIENT/OUTPATIENT - 01
DOC IND

RUN DATE 06/12/2012 000088198
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID

RECIP NAME JACOB J MARKS

DOB 12/06/1996 SEX M

INSURANCE EDITS

NPI: 1508017476 TAXONOMY: 323P00000X PRV ZIP: 29690-0968
51) RTF031 3) 00135 4) 113 6) 06/03/12 06/07/12 7) 000 005 60) MEDICAID RCP ID 3373561202
17) 07/07/11 19) 9 20) 2 22) 30 23) 00135 24) CS 25) 26) 27) 28) 29) 30) 000-553 000-951

** AGENCY USE ONLY
** APPROVED EDITS

| CLAIMS/LINE PAYMENT INFO |
| EDIT PAYMENT DATE |
|*****|

41A)
41B)
41C)
41D)

40A)
40B)
40C)
40D)

MEDICAID CARRIER ID 619
1ST OTHER PAYER 50)
2ND OTHER PAYER 50)

REIMBURSEMENT A
60)
60)

54P) 63) PP39062 DRG
(67) (68) (69) (70) (71) (72) (73) (74) (75) (76)
314.01 (Y) 314.01
80) 81C) 81A) 81B) 81D) 81E) 81F) 81G) 81H) 81I)
RES LN 001 120 (42) (44) (45) (46) (47) (48) (49) (50) (51)
TOTAL CHARGES 001 120 (42) (44) (45) (46) (47) (48) (49) (50) (51)
0.00 0.00 1455.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00
(NDC)

INSURANCE POLICY INFORMATION

RESOLUTION DECISION
RETURN TO: MEDICAID CLAIMS RECEIPT, P.O. BOX 1458, COLUMBIA, SC 29202-1458
PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"



Avalonia Group Homes, Inc.
P.O. Box 699
Marietta, SC 29661

RECEIVED

JUN 15 2012

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Director Anthony Keck
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206



UNITED STATES POSTAGE
PITNEY BOWES
02 1P
\$000.65⁰
0003245995 JUN 13 2012
MAILED FROM ZIP CODE 29609

29202+8206



EXCALIBUR YOUTH SERVICES, LLC.



RECEIVED

JUN 15 2012

Department of Health & Human Services
OFFICE OF THE DIRECTOR

June 13, 2012

Mr. Anthony Keck
Director
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

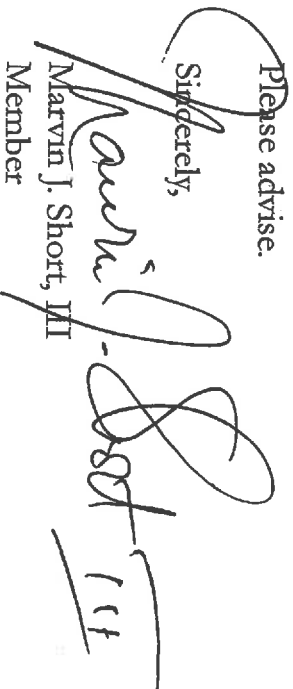
Re: Remittance Advice dated 06/15/2012

Dear Director Keck:

I wanted to bring your attention to the Remittance Advice for our Venice location. We should have received funds in the amount of \$25,317.00, but report is showing we will be receiving \$226,107.00. This will result in an overpayment of \$200,790.00, if it is paid Friday, June 15, 2012.

Please advise.

Sincerely,


Marvin J. Short, III
Member

Enclosure

VENICE

PO BOX 968
TRAVELERS REST

, SC 29690-0968

ATTENTION 000022848

EFFECTIVE JULY 1, 2012, CLAIMS OR SERVICES THAT REQUIRE PRIOR AUTHORIZATION FROM THE QIO (KEPRO) WILL AUTOMATICALLY REJECT IF THE AUTHORIZATION NUMBER IS NOT PRESENT ON THE CLAIM OR IS INVALID. PLEASE REFER TO THE MEDICAID BULLETIN DATED APRIL 11, 2012 FOR A COMPLETE LIST OF SERVICES THAT REQUIRE PRIOR AUTHORIZATION FROM KEPRO.

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	DAYS	AMOUNT BILLED	TITLE 19 PAYMENT ID	S RECIPIENT ID	RECIPIENT ID	RECIPIENT NAME	CO PY	DRG REIM	XOV IND
00147	1215800087485500Z	050212-0517	16	0	4,656.00	0.00	R	8630267772 D J MCDONALD EDITS: I00 859 06/01/12			998-0 G
00120	1216000762440300Z	060112-0607	7	7	2,037.00	2,037.00	P	8630267773 M M MCDONALD			998-0 G
00089	1216000763440300Z	060112-0607	7	7	2,037.00	2,037.00	P	9397630701 D R KAY			998-0 G
00095	1216000764440300Z	060112-0607	7	7	2,037.00	2,037.00	P	2250860804 A R BUSBY			998-0 G
00120	1216000765440300Z	060112-0607	7	136	2,037.00	2,037.00	P	8833066802 K L HAMBY			998-0 G
00120	1216000766440300Z	060112-0607	7	86	2,037.00	2,037.00	P	6048043701 J E SHIPLET			998-0 G
00144	1216000767440300Z	060112-0607	7	51	2,037.00	2,037.00	P	6831114904 S FORRESTER			998-0 G
00146	1216000768440300Z	060112-0607	7	44	2,037.00	2,037.00	P	4150108901 K T SUTTER			998-0 G
00141	1216000769440300Z	060112-0607	7	58	2,037.00	2,037.00	P	8833300501 K ARMSTRONG			998-0 G
00120	1216000770440300Z	060112-0601	1	135	291.00	291.00	P	1781387554 E R BRADDOCK			998-0 G
00091	1216000771440300Z	060112-0607	7	7	2,037.00	2,037.00	P	1835027704 K M LEE			998-0 G
00124	1216000772440300Z	060112-0601	1	1	291.00	291.00	P	4397458401 M E TANT			998-0 G
00143	1216000773440300Z	060112-0607	7	58	2,037.00	2,037.00	P	5243807803 N M ROUSE			998-0 G
00147	1216000774440300Z	060112-0607	7	36	2,037.00	2,037.00	P	8630267772 D J MCDONALD			998-0 G
00120	1216000775440300Z	060312-0607	5	141	1,455.00	41,031.00	P	1781387554 E R BRADDOCK			998-0 G
00124	1216000776440300Z	060312-0606	3	3	873.00	873.00	P	4397458401 M E TANT			998-0 G
TOTALS			16		29,973.00	226,107.00					
CLAIMS			16								

FOR AN EXPLANATION OF THE FORM REFER TO: "MEDICAID ERROR CODES LISTED ON THIS PROVIDER MANUAL".	SCHAP PG TOT	\$0.00	MEDICAID PG TOT	\$226,107.00	STATUS CODES:	PROVIDER NAME AND ADDRESS
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.	SCHAP TOTAL		MEDICAID TOTAL		P = PAYMENT MADE R = REJECTED S = IN PROCESS	VENICE PO BOX 968 TRAVELERS REST SC 29690
	CHECK TOTAL		CHECK TOTAL		CHECK NUMBER	

1083852511

OFFICE OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM
ADJUSTMENTS

06/15/2012

2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MDDYY	BILLED AMOUNT	TITLE 19 PAYMENT MEDICAID S	RECIPIENT ID. NUMBER	LAST NAME I F M O	RECIPIENT NAME M D	ORG CHECK DATE
00120	1216000415700000U				-2037.00 P	13044208602	GUEST V K	120601	1214600927440100Z
	TOTALS			0.00	-2037.00				

PROVIDER
INCENTIVE
CREDIT AMOUNT

DEBIT BALANCE
PRIOR TO THIS
REMITTANCE

-----+-----MEDICAID TOTAL

CERTIFIED AMT

00'0

IN THE FUTURE
0.00

00'0
- - - -

00'0

ADJUSTMENTS

00°0	
------	--

-----+
CHECK TOTAL

+-----CHECK NUMBER

YOUR CURRENT
DEBIT BALANCE

224070.00

6989370

PROVIDER NAME AND ADDRESS

PO BOX 968
TRAVELERS REST

SC 29690

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: BRANCH BANK & TRUST
NOTIFY MEDICAID PROVIDER ENROLLMENT

BANK NUMBER: 053201607 ACCOUNT #: XXXXXXXXXX9595
RE CLOSING OR CHANGING YOUR BANK ACCOUNT.

Excalibur Youth Services, LLC
P.O. Box 968
Travelers Rest, SC 29690



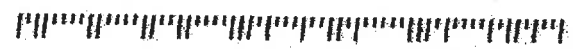
RECEIVED
JUN 15 2012

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Anthony Keck
Director

SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

29202+8206



Log #486

June 22, 2012

Mr. Marvin J. Short, III
President
Avalonia Group Homes, Inc.
PO Box 969
Travelers Rest, South Carolina 29690

Dear Mr. Short:

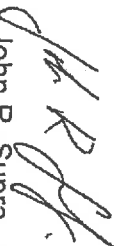
This is letter is in response to your inquiry regarding the June 15, 2012 Remittance Advices (RA) for both the Avalonia Group Homes, Inc. - Hampton and Excalbur Youth Services, LLC - Venice locations. The RA error was the result of a system modification to the Statement Covers Period (sponsored days). Instead of modifying for a bill type of 111 (admission through discharge), the RA was modified to include interim bill types (113, 114) causing inflated sponsored days. The sponsored days are used in the reimbursement calculation which created the overpayment.

We have corrected the problem and will void and replace the claims paid on the June 15, 2012 RA. Any claims received since the last payment run have been identified and will be recycled to ensure proper payment. All claims will be processed for payment to be included in your RA for June 29th.

We apologize for any inconvenience this may have caused and appreciate you bringing this to our attention. We are working toward developing better metrics to capture these types of errors prior to payment.

Thank you for the services you provide to our beneficiaries.

Sincerely,


John R. Supra, Jr.
Deputy Director