DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	5/26/09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10657	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Ref Log # 505 Attached note from Nancy.	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] 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.			

RUN DATE 05/12/2009 000151944
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID
TAXONOMY: 2080P0006X

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM

HIC - 20 PRAC SPEC - 22
DOC IND N

CLAIM CONTROL #09124145360451O0A
PAGE 72525 ECF 72525 PAGE 1 OF 1
EMC
ORIGINAL CCN:
ADJ CCN:

SFL ZIP:
PRV ZIP: 29307

1 PROV/XWALK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 DIAGNOSIS SECONDARY
080646	9730931301						341.9	300.3

NPI: 1942303185

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 510 852
02) 510

10 RECIPIENT NAME - HALEY M CANNON

11 DATE OF BIRTH 07/09/1995 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	23 NDC	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	PAY	21 22 UNITS
	.00	1	10/25/07	11	99215	000		080646	90.00		1.000
	NPI: 1942303185		TAXONOMY:								
	.00	2	02/08/08	11	99214	000		080646	65.00		1.000
	NPI: 1942303185		TAXONOMY:								
		3	/ /								
	NPI:		TAXONOMY:								
		4	/ /								
	NPI:		TAXONOMY:								
		5	/ /								
	NPI:		TAXONOMY:								
		6	/ /								
	NPI:		TAXONOMY:								
		7	/ /								
	NPI:		TAXONOMY:								
		8	/ /								
	NPI:		TAXONOMY:								

AGENCY USE ONLY
APPROVED EDITS

REJECTED LINE EDITS

CLAIMS/LINE PAYMENT INFO

EDIT	PAYMENT DATE
01-852	11/09/07

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27 TOTAL CHARGE 155.00
28 AMT REC'D INS
29 BALANCE DUE 155.00
30 OWN REF # MOSHERH

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 05/12/2009 000151945
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID
TAXONOMY: 2080P0006X

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 22
DOC IND N

SFL ZIP:
PRV ZIP: 29307

CLAIM CONTROL #09124145370451 00A

EMC
ORIGINAL CCN:
ADJ CCN:

1 PROV/XWALK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY	9 SECONDARY
080646	2424546704						314.07	309.28

NPI: 1942303185

EDITS
INSURANCE EDITS

CLAIM EDITS
700

LINE EDITS
01) 510 852

10 RECIPIENT NAME - BRANDON FARR

11 DATE OF BIRTH 07/22/1994 12 SEX M

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	09/25/07	11	99245	000	080646	450.00		1.000

23 NDC

NPI: 1942303185 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
** REJECTED LINE EDITS **
**
****

CLAIMS/LINE PAYMENT INFO

EDIT	PAYMENT DATE
01-852	11/09/07

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27	TOTAL CHARGE	450.00
28	AMT REC'D INS	
29	BALANCE DUE	450.00
30	OWN REF #	FARRB

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

INSURANCE POLICY INFORMATION

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Ref Log #505
log per BZ

Living With ADD

Dr. Daniel L. Moore, MD
2375 East Main Street, Suite A-311
Spartanburg, South Carolina 29307

phone: (864) 579-3960
fax: (864) 579-1368

- DATE: 5/21/09
- ATTENTION: Melanie "BZ" Giese, RN & M. Laureen Dyar
  Fax Number: 803-255-8353 803-255-8255
- NUMBER OF PAGES (including this cover sheet): 3
- ADDITIONAL NOTES: These have been rejected again!
  Code: 852
  Code: 510 - because we have to keep refiling

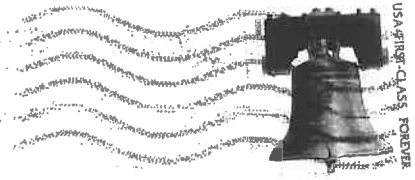
IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE CONTACT OUR OFFICE OR FAX THIS BACK TO US.

From: Felicity Myers
To: Brenda James; Margarete Keller
Date: 5/26/2009 5:44 pm
Subject: log 657

please relog as necessary action

DANIEL L. MOORE, M.D.
2375 EAST MAIN STREET, SUITE A-311
SPARTANBURG, SOUTH CAROLINA 29307

GREENVILLE SC 296
22 MAY 2009 PM 1 L



RECEIVED
MAY 26 2009
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Melanie "BZ" Giese, RN
Bureau Director of Health Services
P.O. Box 8206
Columbia, S.C. 29202-8206

29202+8206

Log 000657:

6-3-09

Provider is being paid by adjustment (copies attached). We have made contact with provider notifying them of forthcoming payment.

Erica

6-3-09

Brenda-

You can add to the file - even though a necessary action. Think we will hear from the manager again.

Nancy

COPY

South Carolina
Department of Health and Human Services
ADJUSTMENT REQUEST

Adjustment/Alternate Claim Form

1. Claim Control Number (Do not write in this area)

PART I- PROVIDER INFORMATION

2. Provider Name: DANIEL L MOORE, MD

3. NPI: 1942303185

4. Prov. Medicaid ID: 080646

5. Submitter ID: ISR100

6. SFY: 08

7. Reason Code: 11

8. Own Reference Number: 025 1MR

PART II- ADJUSTMENT REASON

9.
- [X] A Claim adjustment that cannot be completed through the Form 130 process (describe in comments)
- [ ] B Expired Check Reissue
- [ ] C FQHC Final Settlement
- [ ] D FQHC Interim Settlement
- [ ] E Graduate Medical Education Payment for MCO Patients
- [ ] F Home Health Final Settlement
- [ ] G Home Health Interim Settlement
- [ ] H Hospital Administrative Days Payment
- [ ] I Hospital Disproportionate Share Payment
- [ ] J Hospital Interim Bill Payment
- [ ] K Managed Care Newborn Kicker Payment
- [ ] L Managed Care Maternity Kicker Payment
- [ ] M Managed Care Retro Newborn Recoupment
- [ ] N Managed Care Sanction
- [ ] O MMA Clawback
- [ ] P Nursing Home Final Settlement
- [ ] Q Nursing Home Interim Settlement
- [ ] R Organ Transplant Payment
- [ ] S Other Cost Settlement (describe in comments)
- [ ] T Rate Change
- [ ] U Receivable
- [ ] V Retrospective QIO Recoupment
- [ ] W RHC Final Settlement
- [ ] X RHC Interim Settlement
- [ ] Y Small Hospital Access Payment
- [ ] Z Teaching Physician Supplemental Payment
- [ ] Aa TPL Recovery
- [ ] Bb Other (describe in comments)
- [ ] Cc Program Integrity Recoupment

Comments (if applicable)

Provider hand wrote all claim forms and would put dollar amount and indicated cents with a dash. Therefore, MMIS paid dollars as cents. This is part of a log letter.

PART III – ACCOUNTS RECEIVABLE USE ONLY

10. Receivable Number

11. Refund Amount

12. Refund Receipt Number

PART IV – GROSS AMOUNT

13. Debit Amount

14. Credit Amount: 0000033.68

15. Requester Signature

16. 6/2/2009 — Date Submitted

17. 18 — Location Code

18. Authorized Signature

19. Maureen E. Ryan — Contact Person (print or type name)

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

June 2, 2009

Daniel L. Moore, MD
Pediatric Neurology Habili
2375 East Main Street A-311
Spartanburg, SC 29307-1434

0251MR
Own Reference Number

080646
Medicaid Provider ID#

1942303185
Providers NPI #

Dear Provider:

The Division of Physician Services for the reason described below has submitted an adjustment to your Medicaid account with the Department of Health and Human Services:

Patient	Medicaid ID#	DOS	CPT Code	Total Charge	Paid
Brandon Farr	2424546704	9/25/07	99245	450.00	$179.58
Haley M. Cannon	9730931301	10/25/07	99215	90.00	$ 89.90
Haley M. Cannon	9730931301	2/8/08	99214	65.00	$ 65.00

Reason: **Provider mailed check back to us in error. Original check number 4969186**

This adjustment transaction will **Increase** your payment by **$333.68** and will appear on a future Remittance Advice. You will be able to identify this particular adjustment on your Remittance Advice by the indicated reference number listed above and will appear in the "Providers Own Reference Number" column.

As always, your continued participation in the South Carolina Medicaid program is needed and appreciated.

Sincerely,

Maureen E. Ryan
Program Manager
Division of Physician Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-4352
Fax (803) 255-8255

RUN DATE 05/12/2009 000151945
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID
TAXONOMY: 2080P0006X

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
HIC - 20 PRAC SPEC - 22
DOC IND N

CLAIM CONTROL #09124145370451 00A

EMC
ORIGINAL CCN:
ADJ CCN:

SFL ZIP:
PRV ZIP: 29307

1 PROV/XWALK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 DIAGNOSIS SECONDARY
080646	2424546704						314.07	309.28

NPI: 1942303185

EDITS
INSURANCE EDITS

CLAIM EDITS
700

LINE EDITS
01) 510 852

10 RECIPIENT NAME - BRANDON FARR

11 DATE OF BIRTH 07/22/1994 12 SEX M

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	23 NDC	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	09/25/07	11	99245	000		080646	450.00		1.000

NPI: 1942303185 TAXONOMY:

2	NPI:	TAXONOMY: / /
3	NPI:	TAXONOMY: / /
4	NPI:	TAXONOMY: / /
5	NPI:	TAXONOMY: / /
6	NPI:	TAXONOMY: / /
7	NPI:	TAXONOMY: / /
8	NPI:	TAXONOMY: / /

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** AGENCY USE ONLY **
** APPROVED EDITS **
**
** REJECTED LINE EDITS **
**
****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
! 01-852 11/09/07 !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27	TOTAL CHARGE	450.00
28	AMT REC'D INS	
29	BALANCE DUE	450.00
30	OWN REF #	FARRB

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES:

INSURANCE POLICY INFORMATION

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

17958

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 05/12/2009 000151944 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #091241453604510OA
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 72525 ECF 72525 PAGE 1 OF 1
ANALYST ID HIC - 20 PRAC SPEC - 22 EMC
SIGNON ID DOC IND N ORIGINAL CCN:
TAXONOMY: 2080P0006X SFL ZIP: PRV ZIP: 29307 ADJ CCN:

1 PROV/XWALK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 SECONDARY
080646	9730931301						341.9	300.3

NPI: 1942303185

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 510 852
02) 510

10 RECIPIENT NAME - HALEY M CANNON 11 DATE OF BIRTH 07/09/1995 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	19 INDIVIDUAL PROV/XWALK	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	10/25/07	11	99215	000	080646	90.00		1.000
	NPI: 1942303185		TAXONOMY:							
	.00	2	02/08/08	11	99214	000	080646	65.00		1.000
	NPI: 1942303185		TAXONOMY:							
	NPI:	3	/ / TAXONOMY:							
	NPI:	4	/ / TAXONOMY:							
	NPI:	5	/ / TAXONOMY:							
	NPI:	6	/ / TAXONOMY:							
	NPI:	7	/ / TAXONOMY:							
	NPI:	8	/ / TAXONOMY:							

23 NDC

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
** REJECTED LINE EDITS **
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****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
! 01-852 11/09/07 !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27	TOTAL CHARGE	155.00
28	AMT REC'D INS	
29	BALANCE DUE	155.00
30	OWN REF #	MOSHERH

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

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COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
DANIEL L MOORE MD
PEDIATRIC NEUROLOGY HABILI
2375 EAST MAIN ST A 311
SPARTANBURG SC 29307-1434

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

$90 line 1
$65. line 2
155.00
-.90 pd.
$154.10 owed
$179.58
$33.368

Ref # 0251MR Way by adjust
TSR100