


DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Bowling/FOIA</i>	DATE <i>7-31-06</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000122</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Singleton, Stensland</i> 	<input checked="" type="checkbox"/> FOIA DATE DUE <i>8-14-06</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. <i>Same letter sent Aug 10th. 2nd Request attached.</i>			
2. <i>cleared 8/18/06, letter attached.</i>			
3.			
4.			

August 21, 2006

Attention: Bryan Kost
Bureau of Information
PO Box 8206
Columbia, SC 29202

Log - Bowling
"FOIPA"
cc: Sam Leitch
Spindland

RECEIVED

JUL 31 2006

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Re: Loving Care Of South Carolina, LLC

Client: Lillie B Lawson
2190 Foster Road
Inman, SC 29349

Dear Mr. Kost,

I am writing this on behalf of my mother, Mrs. Lillie B. Lawson. Born May 24, 1907 (100). She has been a client of Community Long Term Care and received weekly services since August 2005. Due to my mother having Congestive Heart Failure, Community Long Term Care changed her care plan as of August 10 to Loving Care of SC. Mom was to receive 10 hours of homemaking services from an aid, to be broken up over 3 days.

I spoke to Ms. Mildred McIntyre LPN and scheduling agent, representing Loving Care of SC the first week in August. She told me an aid from Loving Care of SC was scheduled to start Monday, August 10. (Before Lunch). My mom and I waited all day for the aid, at 4:30 I called Ms. McIntyre to let her know that their aid had not come and had not telephoned. Ms. McIntyre said she would call the aid, and then call me back. An hour passed when Rita telephoned. I rescheduled for Wednesday August 12, at 9am and gave her directions to our home.

Wednesday August 12, Rita was not at our home at 9am as scheduled and at 10:15 I called Ms. McIntyre and reported Rita had not shown up. Again Ms. McIntyre had to call Rita. Rita called me and said she would be here at 12:00. I told her that time would not work because my mothers nurse and social worker would be here at that time. Rita asked for directions again and said she was on her way.

Rita did show up (she did not apologize for being late) and I asked her to explain her job description. She said she usually did light house keeping in the patient area only. I showed her my moms room, my moms bath room, the porta toilet and the kitchen table area where my mom takes some meals occasionally. She was reluctant to start cleaning and sat down to call her office to check in. I showed her where the cleaning tools were, and she swept in the middle of moms floor and made no effort to pull the hospital bed out to clean around it where there was spilled insure. I pulled the bed

out for her, indicating that it needed cleaning. She sat down again and I handed her the pledge and a cloth to clean the table that mom eats on.

After 1 hour of spot cleaning and sitting for most of the hour, Rita called her office again to check out. I asked her about the scheduled 3 hours. She said she was told to stay for 1 hour only. She also said she didn't like our small dog and acted offended when the dog was in the same area as she was. I told her the dog was part of the family and that my mom loved the dog. Rita left and didn't show up as scheduled for the rest of the week, and this week. She did not telephone me nor did any representative from Loving Care of SC telephone me notifying me of their absence or refusal to work for my mom. I have telephoned Ms. McIntyre and left several messages. She has not returned my phone calls.

I telephoned Loving Care again today and spoke to Helen Johnson, RN, and one of the owners of Loving Care of SC. I tried to discuss the situation with her but she was rude to me and said they were canceling my moms services without notice. I am very discouraged with the LACK of professionalism from an organization who is supposed to:

Keep me informed either orally or in writing of my rights and responsibilities.

To treat my mom and me with consideration, respect, and without discrimination as to race, sex, religion, age, disability, national or ethnic origin.

To keep mom and me informed of the criteria for admission to service and discharge from service of Loving Care of SC, LLC.

To respect and care for our property.

To let me and my mom participate in the development and implementation of the care plan provided by our Case Manager, Courtney Holloman and to be fully informed of discharge or transfer from Loving Care of SC services .

To be informed of the name of the person supervising my moms care and when contacting her be treated with respect.

This is a formal request under the Freedom Of Information Act, asking for copies of any and all records, invoices and bills that have been submitted to your office by Loving Care of SC as they relate to Mrs. Lillie Lawson. I am also requesting under the Freedom of Information act all invoices paid my Medicaid to Loving Care of SC as they pertain to my mother, Mrs. Lillie B. Lawson, 2190 Foster Road, Inman, SC 29349. I suspect false records.

Please forward Medicades appeal process and all necessary paperwork to file an appeal. Thanking you in advance for your consideration.

Sincerely,



Lynn Greca – 864-592-0026 – 2190 Foster Road, Inman, SC 29349



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request

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:	_____	\$ _____

Total Amount Due SCDHHS: \$ _____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8355
Columbia, South Carolina 29202-8355

Please contact _____ should you have any questions.

Signature _____ Date: _____

Finance and Administration
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2503 Fax (803) 898-4515

Log to Susan/KOIA Log #122
Due 8/14/06

August 21, 2006

RECEIVED

AUG 10 2006

Attention: Debra Carter
Div. of Community Long Term Care
PO Box 8206
Columbia, SC 29202

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Re: Loving Care Of South Carolina, LLC
Client: Lillie B Lawson
2190 Foster Road
Inman, SC 29349

Pranda,
Haven't we
logged to Susan
already??

Dear Ms. Carter,

I am writing this on behalf of my mother, Mrs. Lillie B. Lawson. Born May 24, 1907 (100). She has been a client of Community Long Term Care and received weekly services since August 2005. Due to my mother having Congestive Heart Failure, Community Long Term Care changed her care plan as of August 10 to Loving Care of SC. Mom was to receive 10 hours of homemaking services from an aid, to be broken up over 3 days.

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Sincerely



Lynn Greca – 864-592-0026 – 2190 Foster Road, Inman, SC 29349

log #122



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

August 18, 2006

Ms. Lynn Greca
2190 Foster Road
Inman, South Carolina 29349

Dear Ms. Greca:

Thank you for contacting us in regards to the concerns you have in obtaining appropriate care for your mother, Mrs. Lillie B. Lawson. Our agency appreciates the opportunity to be of assistance.

Enclosed please find the following items in response to your request:

- 1) Service Provision Form for Loving Care of South Carolina
- 2) Skeletal Claim history of claims paid to Loving Care for services provided to Mrs. Lawson
- 3) Client Activity Report indicating services billed by Loving Care
- 4) Appeals and Hearings regulations.

It is my understanding that your mother is now receiving services from another Personal Care Agency. It is the right of any participant to determine which provider is selected to provide services and to change providers at any time. Since you have exercised that right on behalf of your mother, the matter appears to be resolved. However, as requested, material is being included that explains the appeals process. There is no particular form needed, as appeals may be made by letter to the Appeals Division of the agency. Our agency has logged this complaint regarding the provider and will keep it in the provider's file.

Thank you for your letter. Should you have further questions or concerns at any time, please contact the case manager who works with your mother, or myself.

Sincerely,

A handwritten signature in dark ink, appearing to read "Susan B. Bowling".

Susan B. Bowling
Deputy Director

SBB/wsk
Enclosures

**Community Long Term Care
Service Provision Form**

**PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY**

**TYPE OF AUTHORIZATION:
New**

Loving Care of South Carolina (EX0564)
401 E Kennedy St., Suite B-6
Farmers Market Place
Spartanburg, SC 29302

From: Spartanburg Area 2
1411 W. O. Ezell Blvd. #6
Spartanburg, SC 29301

**AUTHORIZATION IS HEREBY GIVEN TO PROVIDE THE FOLLOWING SERVICE(S)
UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND
HUMAN SERVICES FOR THE PROVISION THEREOF.**

Service(s) Authorized: Personal Care I (Home mgmt) CLTC PROCEDURE
CODE: S5130

Authorized Start Date: 7/10/2006 Authorized End Date: 7/20/2006
(if applicable)

Comments:

Total Units Authorized: 5 Sun Mon 1 Tue 1 Wed 1 Thur 1 Fri 1 Sat Unit Cost: \$10.10

CLIENT INFORMATION

NAME Lillie Lawson	BIRTHDATE 5/24/1907	SEX Female
ADDRESS 2190 Foster Rd Inman, SC 29349		
CLTC CLIENT NO. 0224950	SOCIAL SEC NO. 250-24-1999	MEDICAID NO. 1780485836
	ELIGIBILITY TYPE 80	
PRIMARY PHONE (864) 592-0026	SECONDARY PHONE (860) 967-9338	THIRD PHONE

RESPONSIBLE PARTY

NAME Lynn Greca	ADDRESS 2190 Foster Rd Inman, SC 29349
RELATIONSHIP Child/In-Law	HOME TELEPHONE (864) 592-0026
	WORK TELEPHONE

Physician: Dr. Mark Martin

Directions to client's home:

Hwy 9 to Boiling Springs, pass Lake Bowen, turn L on Foster Rd, 1st driveway on L, chair link fence

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

AMDCIM05	SC DHHS - SKELETAL HIC CLAIM	08/10/06
CLAIM CTL NO	0619710317421000A	1 OF 1
NAME LILLIE	F LAWSON	
PROV NAME	LOVING CARE OF SC	TPL INDICATOR N
ADDRESS	401 E KENNEDY ST SUITE B6	THIRD PARTY
	SPARTANBURG SC	
ZIP CODE	29302-	TELEPHONE 864-582-3500
CK DATE	07/21/06	AMT PD \$9.09
SUBFILES	*1	PRIOR AUTH
		THIRD PARTY AMT \$9.09
		SEC DIAG

SEL	LINE	DATE OF	PLACE	PROC	PROC	INDIV	PRAC	UNITS	VIS	FUND	AMOUNT
	NO	SERVICE	SER	CODE	MOD	PROV	SP	REMB <td>CODE<td>PAID</td><td></td></td>	CODE <td>PAID</td> <td></td>	PAID	
-	01	07/12/06	12 (4)	S5130	000	EX0564		009	VA		\$9.09

TOTAL CLAIM CHARGE: \$9.09 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

Client Activity Report

August 10, 2006 2:08:09PM

Page 1 of 1

Date Range: 7/1/2006 to 8/10/2006

Total Records Returned: 1

Filtered By: Date Range, CLTC#, Provider ID

Area: All

Sorted By:

Case Manager: Courtni Holloman

Client: Lawson, Lillie

CLTC#: 0224950

Claim #	Date of Service	Worker Name	Worker ID #	CLTC#	Provider Name	Provider ID	Auth Service	Service Performed	Check In	Check Out	Total Units	Auth Units	Billable Units	Total Payment (\$)	Exception Code(s)
I06071205609	07/12/2006	R Reid	05642070	0224950	Loving Care of South Caroli	EX0564	PC1	PC1	10:22 am	11:16 am	0.9	1.0	0.9	9.09	D
Client Totals:											0.9	1.0	0.9	9.09	1

Case Manager Total:	0.9	1.0	0.9	9.09	1
Area Total:	0.9	1.0	0.9	9.09	1

Exception Code Definitions

CODE	DEFINITION
A1	No Authorization To Match Service Delivery
A2	Service Not Performed
B	Non-Authorized Service Period
C1	No CheckIN but CheckOUT exists
C2	No CheckOUT but CheckIN exists
D	Daily Units Provided Less Than Units Authorized
E	Daily Units Provided Exceed Units Authorized
F	Authorized Units Is Greater Than Actual Units
G1	CheckIN and CheckOUT Phone Numbers Do Not Match Authorized
G2	CheckOUT Phone Number Does Not Match Authorized
G3	CheckIN Phone Number Does Not Match Authorized
I1	Worker Entered Is Not Listed to Perform Service
I2	Authorized Worker ID Not Equal To Actual Worker ID
I3	Provider Entered Is Not Listed to Perform Service

CHAPTER 126.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (Statutory Authority: 1976 Code Section 44-6-90)

ARTICLE 1.

ADMINISTRATION

SUBARTICLE 3.

APPEALS AND HEARINGS

126-150. Definitions.

- A. Agency-The Department of Health and Human Services and its employees.
- B. Appeal-The formal process of review and adjudication of Agency determinations, which shall be afforded to any person possessing a right to appeal pursuant to statutory, regulatory and/or contractual law; Provided, that to the extent that an appellant's appellate rights are in any way limited by contract with the Agency or assigned to the Agency, said contractual provision shall control.
- C. Hearing Officer-Any Agency employee appointed by the Director to make Decisions either affirming or reversing Agency program determinations by setting forth findings of fact and conclusions of law in appeals arising under this regulation.
- D. Person-An individual, partnership, corporation, association, governmental subdivision, or public or private agency or organization.
- E. Provider-A person who provides services to individuals under programs administered by the Agency.

126-152. Appeal Procedure.

- A. An appeal shall be initiated by the filing of a notice of appeal within thirty (30) days of written notice of the Agency action or decision which forms the basis of the appeal. The failure to file the requisite notice of appeal within the thirty (30) day period specified above shall render the Agency action or decision final; provided, that should the written notice specify some period to appeal other than thirty (30) days, that period shall apply; provided, that the requirement that written notice be given by the Agency shall not be applicable to situations where applicants for Medicaid benefits acquire the right to appeal when the Agency fails to act on the application within the time period specified by federal regulation.
- B. The notice of appeal shall be in writing and shall be directed to Appeals and Hearings, Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. In appeals by providers, the notice of appeal shall state with specificity the adjustment(s) or disallowance(s) in question, the nature of the Issue(s) in contest, the jurisdictional basis of the appeal and the legal authority upon which the appellant relies.
- C. If a notice of appeal does not satisfy the requirements of paragraph (B) above, the Hearing Officer, upon his own motion or by motion by an adverse party, may require a more definite and certain statement.