DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	3-3-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 080475	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Stensland, Myers, Ms. Forkner Cleared 3/23/09, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 3-17-09 [ ] 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.			

From: Rick Hepfer
To: Jeff Stensland
Date: 3/2/2009 6:05 PM
Subject: Fwd: Targeted Case Management
Attachments: Butkus Announcement 02-27-09.pdf

Here is another FOIA for logging.

>>> "Patricia L Harrison" <plh.cola@worldnet.att.net> 3/2/2009 2:55 PM >>>
Emma and Steve, this is good news. DDSN has confirmed in the attached memo, which was sent to providers and families, that their administrative costs have been less than 2% for the past nine years.

This should mean that private providers of DDSN service coordination (who have already been approved as "qualified providers") should be allowed to bill $245.00 per month for targeted case management services.

Please provide me the forms that private providers of targeted case management must fill out to bill HHS directly and confirm that they will be paid $245.00 per month for this service. I am requesting copies of the forms pursuant to FOIA.

Thank you. You may call me at 803 256 2017 if this is not correct.

Trisha Harrison

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
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 8297
Columbia, South Carolina 29202-8297

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) 255-8235

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State of South Carolina
Department of Health and Human Services

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Log # 000475

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

March 23, 2009

HAND DELIVERED

Ms. Patricia L. Harrison
Attorney at Law
611 Holly St.
Columbia, SC 29205

Re: Request for Information on Case Management

Dear Ms. Harrison:

This is in response to your March 2, 2009, e-mail to Ms. Forkner, and others requesting forms related to enrolling providers of targeted case management (TCM) for direct billing with the Department of Health and Human Services (DHHS). This letter also responds to other inquiries you have made about this service, most recently by e-mail of March 21, 2009.

As you probably know, at the current time, TCMs associated with the Mental Retardation and Related Disabilities (MR/RD) and Head and Spinal Cord Injury (HASCI) waivers are admitted to a qualified provider list through a Request for Proposal let by the Material Management Office of the Budget and Control Board. See http://www.state.sc.us/ddsn/solicitations/RFP_Solicitation_5400000507.rtf. Qualified providers contract directly with the Department of Disabilities and Special Needs (DDSN). They also submit claims for services to DDSN. DDSN in turn submits the claims for TCM to DHHS for payment. Direct billing of these TCM services to DHHS could involve a considerable change in this process. However, other providers of DDSN services bill DHHS directly, and if we receive a bona fide request for direct TCM billing, we will evaluate the possibility of doing so. We see no obvious barrier to doing so, but would like the opportunity to engage all of the State agencies that would be impacted. I have enclosed the normal enrollment forms used for direct billing. There would also be a contract, which would have to be developed.

In your March 2nd e-mail, you asked for confirmation from this Department that directly enrolled TCM providers would be able to bill DHHS the current rate ($250.00) monthly. We are unable to confirm that proposition. TCM is a service involving assessment, care planning, referral and follow-up. The frequency of TCM services depends upon the need or volatility of the particular client and the judgment of the case manager. The average frequency for DDSN clients is about

Office of General Counsel
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2795 Fax (803) 255-8210

every other month, and we would question more frequent utilization, unless there was some unusual circumstance. We are aware that DDSN may use the revenue from TCM billings to pay a monthly rate to their contracted providers, under their band or capitated system. However, as was reiterated in the recent regulations, now under moratorium, Medicaid only pays for the discreet service, and only when it has been rendered.

As always thank you for your interest in these issues. Please contact me if I may answer any questions. I would be happy to discuss this in greater depth. My direct is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

Enclosure

cc: Sam Waldrep, CLTC

South Carolina
Department of Health and Human Services

Forward completed form to: DHHS - Division of Contracts
Post Office Box 8206
Columbia, South Carolina 29202-8206

MEDICAID ENROLLMENT DATA
GROUP COMMUNITY LONG TERM CARE PROVIDER - CONTRACTED

SHADED ITEMS ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE MEDICAID PROVIDER.
ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE BACK OF THIS FORM.

1 Medicaid No.

2 Provider Type: 6 2

4 Sort Key

3 **PROVIDER'S NAME**

5 Tax Payer Identification Name (If different from provider's name)

Physical Location Address
7 **NUMBER AND STREET**

9 **CITY** | 10 **STATE** | 11 **ZIP + 4**

Payment Address (If different from mailing address)
6 In care of, Attention, Building Name, etc.

8 Number and Street, PO Box or Route No.

12 City | 13 STATE | 14 ZIP + 4

15 **COUNTY*** | 16 **TELEPHONE (INCLUDE AREA CODE)** ( ) | 17 **IRS EMPLOYER ID NO.** | 18 Type Ownership

19 EC Indicator: N | 20 Enroll Status | 21 Enroll Date

22 **LIST NAMES AND SC MEDICAID NUMBERS OF CLTC INDIVIDUAL PROVIDERS** who participate in your Medicaid group.
Medicaid numbers are not required when an Individual CLTC Enrollment Form is attached.

Provider Name	Medicaid Number	Provider Name	Medicaid Number

23 **NPI NO.** | 24 **NPI ISSUE DATE**

25 **TAXONOMY CODE** | Taxonomy Code | Taxonomy Code

ATTENTION: A statistically valid random sampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I certify that the enrollment information I have furnished is true, accurate, and complete and that I will report any changes affecting my enrollment. I further certify that I will obtain authorization from each Medicaid Patient to release to SCDHHS medical information necessary for processing Medicaid claims.

Signature and Title of Authorized Agent: _____ Date _____
A facsimile stamp is not acceptable.

South Carolina
Department of Health and Human Services

Forward completed form to: DHHS - Division of Contracts
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Columbia, South Carolina 29202-8206

MEDICAID ENROLLMENT DATA
INDIVIDUAL COMMUNITY LONG TERM CARE - CONTRACTED

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ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
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Physical Location Address
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9 **CITY** | 10 **STATE** | 11 **ZIP + 4**

Payment Address (If different from mailing address)
6 In care of, Attention, Building Name, etc.

8 Number and Street, PO Box or Route No.

12 City | 13 STATE | 14 ZIP + 4

15 **COUNTY*** | 16 **TELEPHONE (INCLUDE AREA CODE)** ( ) | 17 **IRS EMPLOYER ID NO.** | -OR- | 18 **SOCIAL SECURITY NO.**

List in Field 5 the Tax Payer Name that match Id# in Field 17 OR 18

19 EC Indicator: N

20 Type Ownership

21 CLTC Group No.

22 Enroll Status

23 Enroll Date

24 **NPI NO.**

25 **NPI ISSUE DATE**

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