

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

**ACTION REFERRAL**

*Reply from Giese to Supra* **TO** *Supra/Sharp* **DATE** *on 11-14-12 per Annie*  
*Due date changed to 11-26-12*  
*10-30-12*

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <b>100131</b>	Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Speck, Post</i> <i>closed 11/15/12, letter</i> <i>attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>11-26-12</i> <input type="checkbox"/> FOIA DATE DUE _____ <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>11-14-12</i>
2.			<i>Didn't know that response had not been done until Annie McEneaney gave back to me on 11-14-12.</i>
3.			
4.			

JAMES E. CLYBURN  
6TH DISTRICT, SOUTH CAROLINA

COMMITTEE:  
DEMOCRATIC STEERING  
AND POLICY COMMITTEE

ASSISTANT DEMOCRATIC LEADER



CONGRESSIONAL BLACK CAUCUS

CHAIR  
FAITH WORKING GROUP

[www.house.gov/clyburn](http://www.house.gov/clyburn)  
[assistantdemocraticleader@house.gov](mailto:assistantdemocraticleader@house.gov)

Congress of the United States  
House of Representatives  
Washington, DC 20515-4006

October 24, 2012

RECEIVED

OCT 30 2012

Mr. Anthony Keck  
Director  
S.C. Department of Health & Human Services  
PO Box 8206  
Columbia, SC 29202

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

RE: Ms. Becky Graham  
Advantage O&P  
Florence, SC, 29505

Dear Mr. Keck:

In an effort to be of service to the above referenced constituent, I am forwarding the enclosed information to you for review. Any assistance you may be able to provide in this matter would be greatly appreciated.

If you need any additional information, please contact Kenny Barnes of my Florence office at (843) 662-1212. You may direct your response to that office at P.O. Box 6286, Florence, S.C. 29502.

With kindest regards, I am,

Sincerely,

James E. Clyburn  
Member of Congress

JEC: kb

2135 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20518-4006  
(202) 225-3315  
(202) 225-2313 FAX

H-132, THE CAPITOL  
WASHINGTON, DC 20515  
(202) 226-3210  
(202) 225-9253 FAX

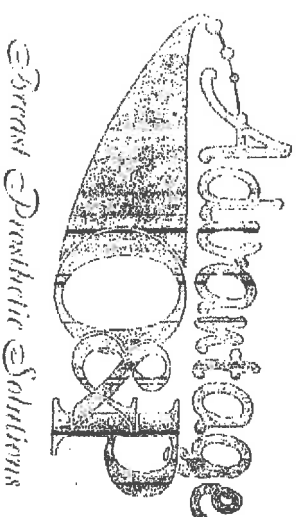
1225 LADY STREET  
SUITE 200  
COLUMBIA, SC 29201  
(803) 799-1100  
(803) 799-9060 FAX

181 EAST EVANS STREET  
FLORENCE, SC 29506  
(843) 662-1212  
(843) 662-8474 FAX

176 BROOKS BOULEVARD  
SANTTEE, SC 29142  
(803) 854-4700  
(803) 854-4900 FAX

129 SOUTH HARVIN STREET  
SUMTER, SC 29150  
(803) 883-5020  
2ND & 4TH MONDAYS

2295 SOUTH IRBY STREET  
FLORENCE, SC 29505



October 19, 2012

Congressman Jim Clyburn

PO Box 6286

Florence SC 29502

Attn: Kenny Barnes

Dear Congressman Clyburn,

I am an employee of Advantage O&P at 2295 S Irby Street, Florence SC 29505. I am writing this letter requesting your assistance in retrieving a refund back from SC Department of Health and Human Service (Medicaid).

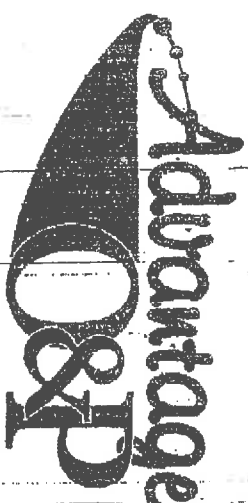
I have tried contacting someone with the Medicaid department to get this matter resolved. I was informed that there is no one that I can speak with. Please see attached letter that was sent to SCDHHS originally on 10/05/2012, then again on today due to having to add the bureau of fiscal affairs in the address.

If you have any further questions please feel free to call my office at (843)673-9995,

*Becky Graham*  
Becky Graham

Insurance Department

2295 SOUTH IREY STREET  
FLORENCE, SC 29505



October 19, 2012

Department of Health Human Services

Bureau of Fiscal Affairs

PO Box 8206

Columbia SC 29202-8206

Reference # 341105, (NPI# 1003864257, legacy# DE2592)

Dear Health Human Services,

This letter is for the request of a refund for Advantage O & P NPI# 1003864257. Legacy # DE2592. On 07/05/2012 form 130 was completed and mailed in along with a check #6380 in the amount of \$565.99 for the refund of a claim paid that was billed in error.

Meanwhile Medicaid had also processed a recoupment for the same amount in which my company Advantage O&P had repaid by company check#6380 on 07/05/2012. This letter is to request a refund in the amount of \$35.58 which was also taken back on 08/03/2012 to fulfill the debit balance.

Please feel free to call me with any questions you may have in regards to this matter.

Sincerely

*Becky Graham*

Becky Graham, Insurance

OFFICE (843) 673-9998

\* CELL (843) 615-3593

FAX (843) 669-4729

PROVIDER ID.

000010922

DEPT OF HEALTH AND HUMAN SERVICES

CLAIM

PAYMENT DATE

06/29/2012

10038664257

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS  
OWN REF.  
NUMBER

CLAIM  
REFERENCE  
NUMBER

12174000217000000

395

01  
02  
03

SERVICE RENDERED  
DATE(S)  
IND MDDYY  
PY

AMOUNT  
BILLED

TITLE 19 S  
PAYMENT T  
MEDICAID S  
NUMBER

RECIPIENT  
LAST NAME I  
F M I

ORG  
CHECK  
DATE

ORIGINAL CON

TOTALS

00001

-1071.44

-565.99

MEDICAID TOTAL

CERTIFIED AMT

0.00

TO BE RETURN  
IN THE FUTURE

PROVIDER  
INCENTIVE  
CREDIT AMOUNT

0.00

DEBIT BALANCE  
PRIOR TO THIS  
REMITTANCE

0.00

ADJUSTMENTS

-565.99

CHECK TOTAL

CHECK NUMBER

0.00

PROVIDER NAME AND ADDRESS

ADVANTAGE O AND P

2295 S IRBY ST

FLORENCE

SC 29505

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.

CERT. PG TOT  
MEDIACID PG TOT  
\$35.58  
MEDIACID TOTAL  
CHECK TOTAL  
STATUS CODES:  
P = PAYMENT MADE  
R = REJECTED  
S = IN PROCESS  
E = ENCOUNTER  
CHECK NUMBER

PROVIDER NAME AND ADDRESS  
ADVANTAGE O AND P  
2295 S IRBY ST  
FLORENCE  
SC 29505

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED DATE(S) PY IND MDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT I S	RECIPIENT ID. NUMBER	RECIPIENT NAME I I LAST NAME	M O D CHANGES	TITLE 18 COPAY AMT	TITLE 18 PAYMENT
1292	1220800795813500A	013112	18030	299.99	35.58	7343000901	D J DUFFEE	ORT	0.00	0.00
TOTALS	1			299.99	35.58				0.00	0.00

2

- 50567-08

Date:

07/05

2012

Pay to the Order of

(address if needed)

South Carolina Department of Health and Human Services  
Cash Receipts  
PO Box 8355

Columbia SC 29202-8355

Explanation (list each item separately):

Billed in error. Claim billed to Advantage OAP by  
Mistake. Re-billed Claim to RPI Medicaid has  
Pd.Account Number  
2455415201Amount  
\$15.99☒ Return to me  
☐ Mail to above address

Signed

B. Graham

For accounting use only:

Check number

6380

Date written

7-5-12

Written by

TF

Medicaid Check  
Rec'd 7/16/12  
ON



**ADVANTAGE O&P, LLC**

2295 SOUTH RUBY STREET  
FLORENCE, SC 29505

038

DATE 7-5-12

PAY  
TO THE  
ORDER OF

South Carolina Department of Health & Human Services

\$ 565.00

Due Medicaid Monthly Office + 99/100

DOLLARS

**FIRST CITIZENS**

First Citizens Bank & Trust Company, Inc.

FOR DEPOSIT ONLY  
Check # 2453415301

⑆006380⑆ ⑆053201487⑆38163 525570⑆⑆

Don't forget to sign

PROVIDER ID. 000009971

PROFESSIONAL SERVICES

PAYMENT DATE

PAGE

100386425

DEPT OF HEALTH AND HUMAN SERVICES

REMITTANCE ADVICE

06/22/2012

1

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT T MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
1762	216500351813300A 01		060712	L8000	295.90 295.90	149.00 P 149.00 P	9451699701	L C SINGLETARY				
2395	216600744813600A 01		061412	L8030	1071.44 438.75	565.99 P 225.12 P	2455915201	H MCCREA	ORT		3.40	0.00
	02		061412	L8000	355.08	182.88 P	(ERROR) Void C/m.		ORT		3.40	0.00
	03		061412	L8020	277.61	157.99 P			ORT		0.00	0.00
2395	216600784813600A 01		061412	L8000	1071.44 355.68	565.99 P 179.48 P	8266860002	L J WILSON	ORT		3.40	0.00
	02		061412	L8020	277.61	157.99 P			ORT		0.00	0.00
	03		061412	L8030	438.75	228.52 P			ORT		0.00	0.00
TOTALS		3			2438.78	1280.98					0.00	0.00

\$1,280.98

STATUS CODES:

PROVIDER NAME AND ADDRESS

FOR AN EXPLANATION OF THE  
ERROR CODES LISTED ON THIS  
FORM REFER TO: "MEDICAID  
PROVIDER MANUAL"

CERT. PG. TOT.

MEDICAID PG. TOT.

P = PAYMENT MADE

ADVANTAGE O AND P

R = REJECTED

S = IN PROCESS

E = ENCOUNTER

2295 S IRBY ST

FLORENCE

SC 29505

IF YOU STILL HAVE QUESTIONS  
PHONE THE D.H.H.S. NUMBER  
SPECIFIED FOR INQUIRY OF  
CLAIMS IN THE MANUAL.

\$0.00

\$0.00

\$1,280.98

6994142

CHECK TOTAL

CHECK NUMBER

FUNDS AUTOMATICALLY DEPOSITED TO:

BANK NAME: 1ST CITIZ BKETR CO SC ACCOUNT #: XXXXXXXX5701  
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERENCE

TO	DATE
<i>Lyise</i>	

*Ben - This was in B2's box today. I took to Jon cause I thought you were re-bagging to Wood Shape. This looks like the original Blue Steel code if someone else picked it up by mistake. Let me know if we should do anything Thanks Anne 11/15/12*

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER	100131	<input checked="" type="checkbox"/> Prepare reply for the Director's signature DATE DUE <u>11-7-12</u>	
2. DATE SIGNED BY DIRECTOR	<i>cc: Mr. Speck, Post</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input type="checkbox"/> FOIA DATE DUE _____ <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.			
2.			
3.			
4.			

**JAMES E. CLYBURN**  
6TH DISTRICT, SOUTH CAROLINA

ASSISTANT DEMOCRATIC LEADER



COMMITTEE:  
DEMOCRATIC STEERING  
AND POLICY COMMITTEE

CONGRESSIONAL BLACK CAUCUS

CHAIR  
FAITH WORKING GROUP

[www.house.gov/clbun](http://www.house.gov/clbun)  
[assistantdemocraticleader@house.gov](mailto:assistantdemocraticleader@house.gov)

**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515-4006**

October 24, 2012

**RECEIVED**

OCT 30 2012

Mr. Anthony Keck  
Director

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

S.C. Department of Health & Human Services  
PO Box 8206  
Columbia, SC 29202

RE: Ms. Becky Graham  
Advantage O&P  
Florence, SC, 29505

Dear Mr. Keck:

In an effort to be of service to the above referenced constituent, I am forwarding the enclosed information to you for review. Any assistance you may be able to provide in this matter would be greatly appreciated.

If you need any additional information, please contact Kenny Barnes of my Florence office at (843) 662-1212. You may direct your response to that office at P.O. Box 6286, Florence, S.C. 29502.

With kindest regards, I am,

Sincerely,

James E. Clyburn  
Member of Congress

JEC: kb

2135 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-4006  
(202) 225-3315  
(202) 225-2313 FAX

H-132, THE CAPITOL  
WASHINGTON, DC 20515  
(202) 225-3210  
(202) 225-9253 FAX

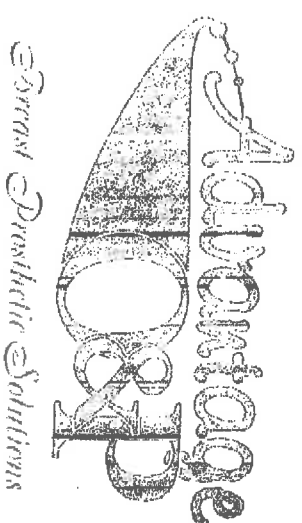
1225 LADY STREET  
SUITE 200  
COLUMBIA, SC 29201  
(803) 799-1100  
(803) 799-9060 FAX

181 EAST EVANS STREET  
FLORENCE, SC 29506  
(843) 662-1212  
(843) 662-6474 FAX

176 BROOKS BOULEVARD  
SARTER, SC 29142  
(803) 854-4700  
(803) 854-4900 FAX

129 SOUTH HARVIN STREET  
SUMTER, SC 29150  
(803) 883-6020  
2ND & 4TH MONDAYS

2295 SOUTH IRBY STREET  
FLORENCE, SC 29505



October 19, 2012

Congressman Jim Clyburn

PO Box 6286

Florence SC 29502

Attn: Kenny Barnes

Dear Congressman Clyburn,

I am an employee of Advantage O&P at 2295 S Irby Street, Florence SC 29505. I am writing this letter requesting your assistance in retrieving a refund back from SC Department of Health and Human Services (Medicaid).

I have tried contacting someone with the Medicaid department to get this matter resolved. I was informed that there is no one that I can speak with. Please see attached letter that was sent to SCDHHS originally on 10/05/2012, then again on today due to having to add the bureau of fiscal affairs in the address.

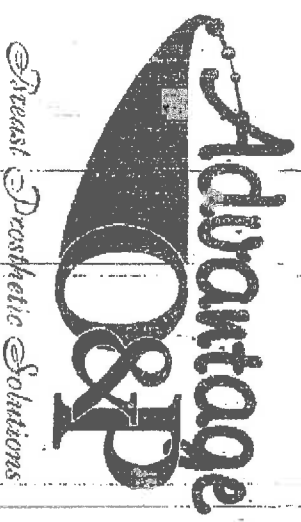
If you have any further questions please feel free to call my office at (843)673-9995.

*Becky Graham*

Becky Graham

Insurance Department

2295 SOUTH IREY STREET  
FLORENCE, SC 29505



October 19, 2012

Department of Health Human Services

Bureau of Fiscal Affairs

PO Box 8206

Columbia SC 29202-8206

Reference # 341105, (NPI# 1003864257, Legacy# DE2592)

Dear Health Human Services,

This letter is for the request of a refund for Advantage O & P NPI# 1003864257. Legacy # DE2592. On 07/05/2012 form 130 was completed and mailed in along with a check #6380 in the amount of \$565.99 for the refund of a claim paid that was billed in error.

Meanwhile Medicaid had also processed a recoupment for the same amount in which my company Advantage O&P had repaid by company check#6380 on 07/05/2012. This letter is to request a refund in the amount of \$35.58 which was also taken back on 08/03/2012 to fulfill the debit balance.

Please feel free to call me with any questions you may have in regards to this matter.

Sincerely

*Becky Graham*

Becky Graham, Insurance

OFFICE (843) 673-9998

\* CELL (843) 615-3593

FAX (843) 669-4729

CLAIM  
ADJUSTMENTS

06/29/2012

1

[illegible]

PROVIDER ID. 000050054  
DEPT OF HEALTH AND HUMAN SERVICES  
SOUTH CAROLINA MEDICAID PROGRAM  
PROFESSIONAL SERVICES  
REMITTANCE ADVISE  
PAYMENT DATE 08/03/2012  
PAGE 1

PROVIDERS OWN REP. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MDDYY	PROC.	AMOUNT BILLED	TITLE 19 MEDICAID PAYMENT	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D CHARGES	TITLE 18 COPAY	TITLE 18 PAYMENT
1292	1220800785813500A	01	013112	L8030	299.99	35.58	P 7343000901	D J DUFFEE	ORT	0.00	0.00
	TOTALS	1			299.99	35.58				0.00	0.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".	CERT. PG TOT	CERTIFIED AMT	STATUS CODES:	PROVIDER NAME AND ADDRESS
			P = PAYMENT MADE R = REJECTED S = IN PROCESS E = ENCOUNTER	ADVANTAGE O AND P 2295 S IRBY ST FLORENCE SC 29505
			CHECK TOTAL	CHECK NUMBER
			MEDICAID PG TOT	
			MEDICAID TOTAL	

IF YOU STILL HAVE QUESTIONS  
SPECIFIED FOR INQUIRY OF  
PHONE THE D.H.H.S. NUMBER  
CLAIMS IN THAT MANUAL.



PROVIDER ID: 000050055 DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM		CLAIM ADJUSTMENTS 08/03/2012		PAYMENT DATE 08/03/2012		PAGE 2																																	
PROVIDERS OWN REF. NUMBER 1003864257	CLAIM REFERENCE NUMBER	PY DATE(S) IND MMDDYY	SERVICE RENDERED PROC	AMOUNT BILLED	TITLE 19 MEDICAID PAYMENT 1	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I M O	CHECK DATE ORG	ORIGINAL CGN																														
<table border="1"> <tr> <td colspan="2">TOTALS</td> <td>00000</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="2">                     PROVIDER INCENTIVE CREDIT AMOUNT                      0.00                 </td> <td colspan="2">                     DEBIT BALANCE PRIOR TO THIS REMITTANCE                      565.99                 </td> <td colspan="2">                     MEDICAID TOTAL                      35.58                 </td> <td colspan="2">                     CERTIFIED AMT                      0.00                 </td> <td colspan="2">                     TO BE REFUNDED IN THE FUTURE                      0.00                 </td> </tr> <tr> <td colspan="2">                     YOUR CURRENT DEBIT BALANCE                      565.41                 </td> <td colspan="2">                     ADJUSTMENTS                      -565.99                 </td> <td colspan="2">                     CHECK TOTAL                      0.00                 </td> <td colspan="2">                     CHECK NUMBER                      0.00                 </td> <td colspan="2">                     PROVIDER NAME AND ADDRESS                      ADVANTAGE O AND P                      2295 S IRBY ST                      FLORENCE - SC 29595                 </td> </tr> </table>										TOTALS		00000	0.00	0.00	0.00					PROVIDER INCENTIVE CREDIT AMOUNT 0.00		DEBIT BALANCE PRIOR TO THIS REMITTANCE 565.99		MEDICAID TOTAL 35.58		CERTIFIED AMT 0.00		TO BE REFUNDED IN THE FUTURE 0.00		YOUR CURRENT DEBIT BALANCE 565.41		ADJUSTMENTS -565.99		CHECK TOTAL 0.00		CHECK NUMBER 0.00		PROVIDER NAME AND ADDRESS ADVANTAGE O AND P 2295 S IRBY ST FLORENCE - SC 29595	
TOTALS		00000	0.00	0.00	0.00																																		
PROVIDER INCENTIVE CREDIT AMOUNT 0.00		DEBIT BALANCE PRIOR TO THIS REMITTANCE 565.99		MEDICAID TOTAL 35.58		CERTIFIED AMT 0.00		TO BE REFUNDED IN THE FUTURE 0.00																															
YOUR CURRENT DEBIT BALANCE 565.41		ADJUSTMENTS -565.99		CHECK TOTAL 0.00		CHECK NUMBER 0.00		PROVIDER NAME AND ADDRESS ADVANTAGE O AND P 2295 S IRBY ST FLORENCE - SC 29595																															

Date:

07/05

2002

Pay to the Order of

(address if needed)

South Carolina Department of Health and Human Services  
Cash Receipts  
PO Box 8355  
Columbia SC 29201-8355

Explanation (list each item separately):

Billed in error. Claim billed to Advantage OAP by  
mistake. Re-billed Claim to RPI Medicaid has  
Pd.

Account Number  
2455A15001Amount  
545.99☒ Return to me  
☐ Mail to above address

Signed

B. Graham

For accounting use only:

Check number

6380

Date written

7-5-12

Written by

TF

Medicaid Check  
Rec'd 7/12/12  
ON

ADVANTAGE O&P, LLC  
2235 SOUTH LIBBY STREET  
FLORENCE, SC 29505

038

PAY  
TO THE  
ORDER OF

South Carolina Department of Health & Human Services

\$ 565.9

Five hundred and sixty five + 99/100

DOLLARS

FIRST CITIZENS

First Citizens Bank & Trust Company, Inc.

FOR DEPOSIT ONLY # 2453415301

⑈006180⑈⑈⑈05320⑈⑈87⑈38⑈63 525570⑈⑈

Don Deery

PROVIDER ID. 000009971

100386425

DEPT OF HEALTH AND HUMAN SERVICES

PROFESSIONAL SERVICES

PAYMENT DATE

PAGE

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

06/22/2012

1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE DATE(S) MMDDYY	RENDERED PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TITLE 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
1762	216500351813300A 01		060712	L8000	295.90 295.90	149.00 149.00	P P	9451699701	L C SINGLETARY				
2395	216600744813600A 01		061412	L8030	1071.44	565.99	P	2455915201	H MCCREA	ORT		3.40	0.00
	02		061412	L8000	438.75	225.12	P			ORT		3.40	0.00
	03		061412	L8020	355.08	182.88	P			ORT		0.00	0.00
					277.61	157.99	P			ORT		0.00	0.00
2395	216600784813600A 01		061412	L8000	1071.44	565.99	P	8266860002	L J WILSON	ORT		3.40	0.00
	02		061412	L8020	355.68	179.48	P			ORT		0.00	0.00
	03		061412	L8030	277.61	157.99	P			ORT		0.00	0.00
					438.75	228.52	P					0.00	0.00
	TOTALS	3			2438.78	1280.98						0.00	0.00
						\$1,280.98							

FOR AN EXPLANATION OF THE  
ERROR CODES LISTED ON THIS  
FORM REFER TO: "MEDICAID  
PROVIDER MANUAL"

CERT. PG. TOT.

MEDICAID PG. TOT.

STATUS CODES:

PROVIDER NAME AND ADDRESS

\$0.00

\$1,280.98

P = PAYMENT MADE

ADVANTAGE O AND P

R = REJECTED

S = IN PROCESS

E = ENCOUNTER

2295 S IRBY ST

FLORENCE

SC 29505

CERTIFIED AMT

MEDICAID TOTAL

6994142

CHECK TOTAL

CHECK NUMBER

IF YOU STILL HAVE QUESTIONS  
PHONE THE D.H.H.S. NUMBER  
SPECIFIED FOR INQUIRY OF  
CLAIMS IN THE MANUAL.

FUNDS AUTOMATICALLY DEPOSITED TO:

BANK NAME: 1ST CITIZ BK&amp;TR CO SC ACCOUNT #: XXXXXXXX5701

NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

November 15, 2012

The Honorable James E. Clyburn  
Attention: Mr. Kenny Barnes  
Post Office Box 6286  
Florence, South Carolina 29502-6286

Dear Congressman Clyburn:

We are in receipt of your letter dated October 24, 2012, regarding Ms. Becky Graham of Advantage O & P, Florence, South Carolina 29502-6286. Ms. Graham was requesting assistance in obtaining a refund from the South Carolina Department of Health and Human Services (SCDHHS).

We have located that request and have responded in a letter to Ms. Graham as of November 15, 2012. A credit adjustment in the amount of \$565.99 is being initiated to refund Advantage O & P and will be included in their remittance advice dated November 23, 2012. We have also contacted Ms. Graham to clarify the process for requesting a refund. A copy of the letter that was sent to Ms. Graham explaining the refund is enclosed.

If you have any questions, please contact Ms. Nancy Sharpe, Director of Claims Operations & Provider Relations at 803-898-2828.

Sincerely,

John Supra, CIO  
Office of Information Management

JS/

cc: Anthony Keck  
Bryan Kost

Enclosures

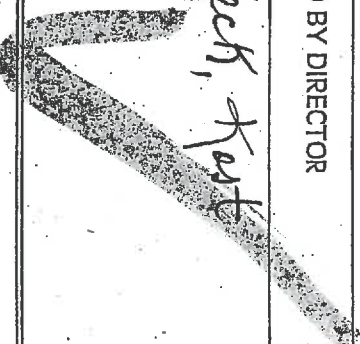
*Not a signed copy.  
Letter was signed per  
Nancy Sharpe on 3/12/13*

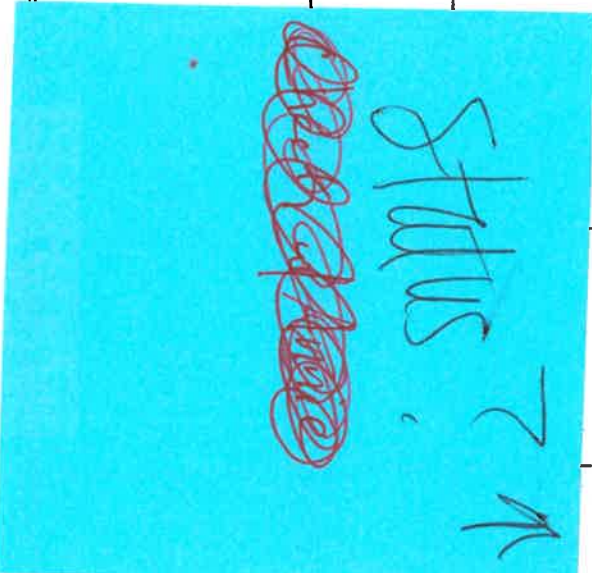
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

**ACTION REFERRAL**

Relog from Giese to Supra on 11-14-12 per Annie

TO <u>Supra/Sharp</u>	DATE Due date changed to 11-26-12 10-30-12
--------------------------	---

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <u>000131</u>		Prepare reply for the Director's signature DATE DUE _____	
2. DATE SIGNED BY DIRECTOR <u>cc: Mr. Speck, Post</u> 		<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <u>11-26-12</u> <input type="checkbox"/> FOIA DATE DUE _____ <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.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Piase</i>	DATE  10-30-12
--------------------	----------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER  100131	<input checked="" type="checkbox"/> Prepare reply for the Director's signature DATE DUE 11-7-12		
2. DATE SIGNED BY DIRECTOR  <i>cc: Mr. Speck, Post</i>		<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input type="checkbox"/> FOIA DATE DUE _____ <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.			
2.			
3.			
4.			

JAMES E. CLYBURN  
6TH DISTRICT, SOUTH CAROLINA

COMMITTEE:  
DEMOCRATIC STEERING  
AND POLICY COMMITTEE



ASSISTANT DEMOCRATIC LEADER

CONGRESSIONAL BLACK CAUCUS

CHAIR  
FAITH WORKING GROUP

[www.house.gov/clyburn](http://www.house.gov/clyburn)  
[astanddemocraticleader.house.gov](mailto:astanddemocraticleader.house.gov)

**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515-4006**

October 24, 2012

**RECEIVED**

OCT 30 2012

Mr. Anthony Keck  
Director  
S.C. Department of Health & Human Services  
PO Box 8206  
Columbia, SC 29202

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

RE: Ms. Becky Graham  
Advantage O&P  
Florence, SC, 29505

Dear Mr. Keck:

In an effort to be of service to the above referenced constituent, I am forwarding the enclosed information to you for review. Any assistance you may be able to provide in this matter would be greatly appreciated.

If you need any additional information, please contact Kenny Barnes of my Florence office at (843) 662-1212. You may direct your response to that office at P.O. Box 6286, Florence, S.C. 29502.

With kindest regards, I am,

Sincerely,

James E. Clyburn  
Member of Congress

JEC: kb

2135 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-4006  
(202) 225-3315  
(202) 225-2313 FAX

H-132, THE CAPITOL  
WASHINGTON, DC 20515  
(202) 226-3210  
(202) 225-9253 FAX

1225 LADY STREET  
SUITE 200  
COLUMBIA, SC 29201  
(803) 799-1100  
(803) 799-9060 FAX

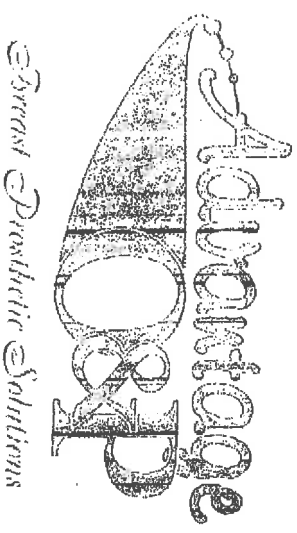
181 EAST EVANS STREET  
FLORENCE, SC 29506  
(843) 662-1212  
(843) 662-8474 FAX

176 BROOKS BOULEVARD  
SANTHE, SC 29142  
(803) 854-4700  
(803) 854-4900 FAX

129 SOUTH HARVIN STREET  
SUMTER, SC 29150  
(803) 883-5020  
2ND & 4TH MONDAYS



2295 SOUTH IRBY STREET  
FLORENCE, SC 29505



October 19, 2012

Congressman Jim Clyburn

PO Box 6286

Florence SC 29502

Attn: Kenny Barnes

Dear Congressman Clyburn,

I am an employee of Advantage O&P at 2295 S Irby Street, Florence SC 29505. I am writing this letter requesting your assistance in retrieving a refund back from SC Department of Health and Human Services (Medicaid).

I have tried contacting someone with the Medicaid department to get this matter resolved. I was informed that there is no one that I can speak with. Please see attached letter that was sent to SCDHHS originally on 10/05/2012, then again on today due to having to add the bureau of fiscal affairs in the address.

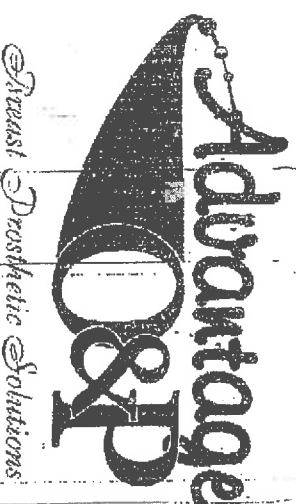
If you have any further questions please feel free to call my office at (843)673-9995.,

*Becky Graham*

Becky Graham

Insurance Department

2295 SOUTH IRBY STREET  
FLORENCE, SC 29505



October 19, 2012

Department of Health Human Services

Bureau of Fiscal Affairs

PO Box 8206

Columbia SC 29202-8206

Reference # 341105, (NPI# 1003864257, Legacy# DE2592)

Dear Health Human Services,

This letter is for the request of a refund for Advantage O & P NPI# 1003864257. Legacy # DE2592. On 07/05/2012 form 130 was completed and mailed in along with a check #6380 in the amount of \$565.99 for the refund of a claim paid that was billed in error.

Meanwhile Medicaid had also processed a recoupment for the same amount in which my company Advantage O&P had repaid by company check#6380 on 07/05/2012. This letter is to request a refund in the amount of \$35.58 which was also taken back on 08/03/2012 to fulfill the debit balance.

Please feel free to call me with any questions you may have in regards to this matter.

Sincerely

*Becky Graham*

Becky Graham, Insurance

OFFICE (843) 673-9998

\* CELL (843) 615-3593

FAX (843) 669-4729



PROVIDER NAME AND ADDRESS  
ADVANTAGE O AND P  
2295 S IRBY ST  
FLORENCE SC 29505

[illegible]

PROVIDER ID: 000550055		DEPT OF HEALTH AND HUMAN SERVICES		SOUTH CAROLINA MEDICAID PROGRAM		CLAIM ADJUSTMENTS		PAYMENT DATE: 08/03/2012		PAGE 2																										
PROVIDER'S OWN REF. NUMBER	1003864257	CLAIM REFERENCE NUMBER		PV IND		SERVICE DATE(S)		PROC		AMOUNT BILLED																										
TITLE 19 S		RECIPIENT ID. NUMBER		LAST NAME I		NAME F		M		ORG CHECK DATE																										
ORIGINAL CCN																																				
<table border="1"> <tr> <td>PROVIDER DEBIT BALANCE PRIOR TO THIS REMITTANCE</td> <td>565.99</td> <td>ADJUSTMENTS</td> <td>-565.99</td> <td>CHECK TOTAL</td> <td>0.00</td> <td>YOUR CURRENT DEBIT BALANCE</td> <td>-560.41</td> </tr> <tr> <td>PROVIDER INCENTIVE CREDIT AMOUNT</td> <td>0.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="4">TOTALS</td> <td>00000</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> </tr> </table>												PROVIDER DEBIT BALANCE PRIOR TO THIS REMITTANCE	565.99	ADJUSTMENTS	-565.99	CHECK TOTAL	0.00	YOUR CURRENT DEBIT BALANCE	-560.41	PROVIDER INCENTIVE CREDIT AMOUNT	0.00							TOTALS				00000	0.00	0.00	0.00	
PROVIDER DEBIT BALANCE PRIOR TO THIS REMITTANCE	565.99	ADJUSTMENTS	-565.99	CHECK TOTAL	0.00	YOUR CURRENT DEBIT BALANCE	-560.41																													
PROVIDER INCENTIVE CREDIT AMOUNT	0.00																																			
TOTALS				00000	0.00	0.00	0.00																													
<table border="1"> <tr> <td colspan="4">MEDICAID TOTAL</td> <td>35.58</td> <td>CERTIFIED AMT</td> <td>0.00</td> <td>PROVIDER NAME AND ADDRESS</td> <td>2295 S IRBY ST FLORENCE - SC 29505</td> </tr> <tr> <td colspan="4">CHECK NUMBER</td> <td>0.00</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="4">TO BE REPUNDED IN THE FUTURE</td> <td>0.00</td> <td></td> <td></td> <td></td> </tr> </table>												MEDICAID TOTAL				35.58	CERTIFIED AMT	0.00	PROVIDER NAME AND ADDRESS	2295 S IRBY ST FLORENCE - SC 29505	CHECK NUMBER				0.00				TO BE REPUNDED IN THE FUTURE				0.00			
MEDICAID TOTAL				35.58	CERTIFIED AMT	0.00	PROVIDER NAME AND ADDRESS	2295 S IRBY ST FLORENCE - SC 29505																												
CHECK NUMBER				0.00																																
TO BE REPUNDED IN THE FUTURE				0.00																																

Date:

07/05

2012

Pay to the Order of

(address if needed)

South Carolina Department of Health and Human Services  
Cash Receipts  
PO Box 8355

Columbia SC 29201-8355

Explanation (list each item separately):

Billed in error. Claim billed to Advantage OAP by  
mistake. Re-billed Claim to RPI Medicaid has  
Pd.

Account Number

2155A15801

Amount

545.99

☒ Return to me  
☐ Mail to above address

Signed

B. Graham

FOR ACCOUNTING USE ONLY:

Check number

6380

Date written

7-5-12

Written by

TF

Medicaid Check  
Rec'd 7/5/12  
On

ADVANTAGE O&P, LLC  
2298 SOUTH HIBBY STREET  
FLORENCE, SC 29505

638

DATE 7.5-12

PAY  
TO THE  
ORDER OF

South Carolina Department of Health & Human Services

\$ 565.00

Five hundred sixty five & 00/100

DOLLARS

FIRST CITIZENS

First Citizens Bank & Trust Company, Inc.

FOR DEPOSIT ONLY  
Account # 2455915301

⑆00003800⑆ ⑆05320487⑆38163 565570⑆⑆

Don King

PROVIDER ID. 000009971  
 100386425 DEPT OF HEALTH AND HUMAN SERVICES  
 SOUTH CAROLINA MEDICAID PROGRAM  
 PROFESSIONAL SERVICES  
 REMITTANCE ADVICE  
 PAYMENT DATE 06/22/2012  
 PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT T MEDICAID S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
1760	216500351813300A 01		060712	L8000	295.90 295.90	149.00 P 149.00 P	9451699701	L C SINGLETARY	ORT		3.40	0.00
2395	216600744813600A 01		061412	L8030	1071.44 438.75	565.99 P 225.12 P	2455915201	H MCCREA	ORT		3.40	0.00
	02		061412	L8000	355.08	182.88 P	(Error) Void Clm		ORT		0.00	0.00
	03		061412	L8020	277.61	157.99 P			ORT		0.00	0.00
2395	216600784813600A 01		061412	L8000	1071.44 355.08	565.99 P 179.48 P	8266860002	L J WILSON	ORT		3.40	0.00
	02		061412	L8020	277.61	157.99 P			ORT		0.00	0.00
	03		061412	L8030	438.75	228.52 P			ORT		0.00	0.00
TOTALS		3			2438.78	1280.98					0.00	0.00

\$1,280.98

STATUS CODES: PROVIDER NAME AND ADDRESS

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 THE MANUAL.

\* FUNDS AUTOMATICALLY DEPOSITED TO:  
 BANK NAME: 1ST CITIZ BK&TR CO SC ACCOUNT #: XXXXXXXX5701  
 NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

CERTIFIED TOT MEDICAID PG. TOT

\$0.00 \$1,280.98

CERTIFIED AMT MEDICAID TOTAL

\$1,280.98

CHECK TOTAL

P = PAYMENT MADE  
 R = REJECTED  
 S = IN PROCESS  
 E = ENCOUNTER

6994142

CHECK NUMBER

ADVANTAGE O AND P  
 2295 S IRBY ST  
 FLORENCE SC 29505