DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	5/21/09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100653	[ ] Prepare reply for the Director's signature DATE DUE [redacted]
2. DATE SIGNED BY DIRECTOR cc/Ms. Forkner Extend until 6/4/09 per myrs on 5/26/09	[X] Prepare reply for appropriate signature DATE DUE 6/4/09 [ ] FOIA DATE DUE [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Change to Approve/Sign per Myers on 6/8/09			
2. Cleared 6/8/09, letter attached.			
3.			
4.			

May 4, 2009

This is being sent and addressed to the following:

S.C. Medicaid Columbia, S.C. Medicaid Conway, S.C., Cabarrus County Medicaid, N.C., S.C. Senator Lindsey Graham and N.C. Senator Kay Hagan.

First I ask all of you to please not bother to reply if I am going to get a generic form letter reply. I can recognize those from far away. Also I am writing on my daughters' behalf and she lives in Murrells Inlet, S.C. and she does not know I am writing this right now. I am just trying to help as any father would.

She is married and 22 years old with two children. They have been struggling as a lot of people are but they are working and maintaining. They are below poverty level and the family does have Medicaid. She has been diagnosed with Crohns and has it severely. Now my understanding is Medicaid is a Federal program with each state putting out its' guidelines as I go on reading. It is hard to read all of it and understand due to being thousands of pages of anything/everything. She has been treated off and on in Myrtle Beach. The G.I. doctor there has his recommendations but Medicaid makes him keep trying everything else but what he says which is a shot. She has to go to the hospital about every other month costing thousands of dollars to get her back under control. Sometimes it is very dangerous these flare ups are very severe. That being said she is at risk of dying or having to wear a coloscopy bag the rest of her life if the intestines are not treated better and they have to take the intestines out. Medicaid is dictating as a doctor here. Some clerk is making life decisions!! Since the doctor has gone to medical school and the clerk has maybe gone to business school, why not let the doctor say what is needed? After all your plan is not working. You have spent $10,000 to save $1000! Does this start to make any sense now?

The next part relates to the above. Last October she came to Mooresville, NC to visit us. She had a major flare up which she has to go to the hospital. We took her to CMC Northeast in Concord, N.C.. She had to stay there a week. They took her Medicaid information and filed it. The S.C. office says they will NOT pay it because she was in N.C.! What difference does that make anyway? It all comes from the same fund! What was she suppose to do? Tell me what would you have done for your daughter or son if needing immediate medical attention? Was I suppose to drive her back 4 hours to Myrtle Beach? Make some sense for me here. I would appreciate it. Now bill collectors are calling and also calling my house! They would have paid it down there so why not just pay it up here?

Lets go back to Welfare. They are trying to get off of welfare. She can't really hold down a job until we get this Crones under control and stabilized. Again with the way Medicaid is playing doctor, this is not a speedy process. In fact you all may just permanently disable her at the way you all dictate and play doctor and that will for sure keep them on welfare the rest of their lives. But also I see by refusing to pay CMC Northeast and the

bill collectors keep calling and putting her on the credit list, they will never be able to buy a home or get a loan for anything. The system here is disabling her, keeping her from getting steady work to get off of welfare, plus it is ruining any chances of credit to move ahead. The whole purpose is being defeated. Now I do understand why I see the same old faces on welfare and the same old faces not moving ahead. Why bother! It is stressful, which reminds me of a big problem with severe Crones is stress. Stress kills and it disables those with Crones.

So I ask one of you all in the group of letters I sent to see who could help. Surely I got at least one person in the group that can step up to the plate and take action. Or am I going to get a run around and lame excuses as why we can't do this or that?

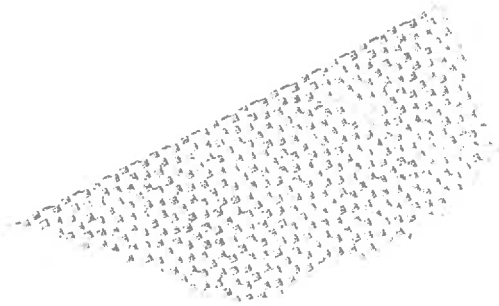
Tell me how a Federal program cannot cross state lines? Usually I write my checks from the same checkbook even if it goes into another state. See what I am saying? Does anyone get it?

Thanks for your help in advance!
Thanks to the one who steps up to the plate as well! I am just looking for the one!

Ron Toney
137 Mandarin Drive
Mooresville, NC 28117
704-737-5417

My Daughter and the Medicaid case is :
Tristan Hershey
151 Chenoa Dr. Apt. F
Murrells Inlet, S.C. 29576

137 MANDARIN DR.
28117



S.C. MEDICAID

P.O. BOX 8206

COLUMBIA, S.C.

ATTN: MANAGER

29202

Log 000652

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

June 8, 2009

Emma Forkner
Director

Mr. Ron Toney
137 Mandarin Drive
Mooresville, North Carolina 28117

Dear Mr. Toney:

Thank you for your recent letter regarding your daughter's care. We welcome the opportunity to be of assistance.

The Health Insurance Portability and Accountability Act (HIPAA) privacy rules restrict us from discussing a beneficiary's care without his/her written consent. If the South Carolina Department of Health and Human Services (SCDHHS) receives the appropriate consent from your daughter (form enclosed), we will be glad to speak with you at your convenience.

Although we are unable to discuss specific claim information at this time, we can outline the policy that mandates our services. Medicaid is a publicly funded insurance program that is Federally and State funded. Every state has its own Medicaid program, and every state has different rules and services. This means that a beneficiary that is eligible in South Carolina may not be eligible in other states. While Medicaid eligibility does not cross state lines, we do authorize some services to be covered out of state. We provide compensation to medical providers outside the South Carolina Medical Service Area (SCMSA) for services rendered to beneficiaries when emergency medical services are necessary to protect the health of the beneficiary traveling outside of the SCMSA. If the Carolinas Medical Center-Northeast in Concord, North Carolina, is having problems submitting their claims for emergency service, please have them contact us. We will assist them to ensure that all emergency claims are reviewed and processed accordingly.

If you should have any further questions or need policy clarification, please do not hesitate to contact Ms. Erica Dimes, Team Leader in Physician Services, at (803) 898-2551. Thank you for taking the time to contact us.

Sincerely,

Felicity Myers, Ph.D.
Deputy Director

FM/gws

Enclosure

Medical Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2501 • Fax (803) 255-8235

SCDHHS AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Record #: _____ Client SS #: _____

I _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan/Agency)

from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)

_____

_____

for the specific purpose(s):_____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____	_____
(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by_____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*