REPORT COMPANION GUIDE

10/11/2016
South Carolina Department of Health and Human Services

MCO REPORTS TO SCDHHS

This Reports Companion Guide is specifically designated for reporting formats that are either required by the division of health services or are sent to the MCO's in relation to a department initiative. Details regarding the reports can be found in both the Contract and the Managed Care Policy and Procedure Guide. All reports received by SCDHHS must be dated for the reporting month, quarter or year being detailed in the report (see below for specific examples and exceptions).

Monthly-- **Example:** "Call Center Performance_201602"
Explanation: Report Name then Calendar Year and Reporting Month (ex. February 2016 data submitted by March 15, 2016)

Quarterly-- **Example:** "Provider Dispute Log_2016FQ1"
Explanation: Report Name then State Fiscal Year and Fiscal Quarter (ex. July – September 2015 data submitted by October 31, 2016)

***** The Report Name should match the Report Requirements Full List below.**

If you have no data to report (ex: Manual Maternity Kicker or TPL COB Savings for pharmacy), still submit the appropriate template and designate that you have 'nothing to report'.

Exceptions: The standard file naming convention does not affect the Encounter Submission Summary, Provider Network file, nor PCMH files. See appropriate sections of this document for specific naming convention.

Specific Program Integrity (PI) or Third Party Liability (TPL) reports that are submitted directly to the PI SharePoint site or to an FTP site, do not need to be submitted to the Health Programs/MCO SharePoint site.

--If you have questions or issues regarding the reports you receive at your FTP site with the department please contact the department's Information Technology helpdesk:

Contact: EDI Support
Hours: 7:00 am to 5:00 pm Monday through Friday
1-888-289-0709, Option 1 and then Option 2
https://www.scdhhs.gov/resource/electronic-data-interchange-edi

--If you have questions about required report submissions or timelines for submission please contact your account manager and they will assist you with your questions.

REPORT REQUIREMENTS

FULL LIST

Report Companion Guide Section Layout and Reporting

Managed Care Report Name	Format	Report Timing
All Reporting Requirements		
Section 2		
Section 2.1.10		
Organizational Chart	Specific Format not defined MCO can utilize any format it chooses to present the data. Must be submitted within 10 business days of change in personnel.	Annually and Upon Change in Personnel
Section 2.2.1.1		
Personnel Resumes	Specific Format not defined MCO can utilize any format it chooses to present the data. Must be submitted for Key personnel within 10 business days of a change.	Upon Change in Key Personnel
Section 3		
Section 3.2		
Eligibility Redetermination	Report produced for MCO's when someone is getting Medicaid eligibility redeterminations completed by SCDHHS.	Monthly
Section 3.4.2		
834 Report Layout	MCO receives these reports on a daily basis providing information on membership enrollment	Daily
Section 3.8		
Manual Maternity Kicker	Maternity Kicker Form for use when automated process does not function correctly	Monthly
Section 3.13.2.1 through 3.13.2.4		
Health Plan Disenrollment	Required for requesting member disenrollment can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary
Nursing Home Notification	Notification of SCDHHS of members entering a nursing home requiring future MCO disenrollment. The online notification can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary
Waiver Enrollment	Notification of SCDHHS of members entering a waiver requiring MCO disenrollment. The online notification can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary
Hospice Enrollment	Notification of SCDHHS of members entering hospice services requiring MCO disenrollment. The online notification can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary
Section 3.19.17		
Call Center Performance	Call center performance metrics for Member English language line, Member Spanish language line, and Provider call center.	Monthly
Section 4		
Section 4.2.21		
Universal PA	Required for providers requesting most pharmaceuticals can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary
Makena 17P	Required for providers requesting the use of Makena and/or 17P for members can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools.	As Necessary
Universal Synagis PA	Required for providers requesting Synagis can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary
Section 4.3.2 through 4.3.4		
Additional Services	Required for requesting additional member services that an MCO would like to provide to encourage desired member outcomes	As Necessary
Section 4.8		
Member Incentives	Required for requesting additional member incentives that an MCO would like to provide to encourage desired member outcomes	As Necessary
Section 5		
Section 5.4.5.1		
Care Management	Report of members receiving care management services on an ongoing basis with the MCO.	Monthly
Section 5.5.1.1		
Universal Newborn PA	Required for out-of-network pediatric providers to obtain an authorization for services rendered in the office during the first 60 days after discharge.	As Necessary
Section 6		
Section 6.3.1 through 6.3.3.3		
Provider Network	MCO report sent to both the enrollment broker and the agency indicating the MCO's current network providers.	Monthly prior to the third Thursday in month
Geoaccess	Sample Map and description of additional data required for report.	Bi-annually and as required

Report Companion Guide Section Layout and Reporting

Managed Care Report Name	Format	Report Timing
Section 7		
Section 7.3.1.1		
Premium Payment Adjustments	MCO's retroactive rate adjustment format.	As Necessary
Dual Medicare Medicaid	Report produced for the MCO's to account for retro-active dual eligible Medicare recoupments for up to a year in arrears.	Monthly
PCMH	Patient Centered Medical Homes. MCO's submission is monthly, SCDHHS pays the MCO's on a quarterly basis. Utilized to reimburse those primary care practices that qualify for this incentive payment.	Monthly
Manual Maternity Kicker	See section 3.8 above.	Monthly
Centering Program	Centering report template provided to MCO's along with reimbursement for centering services provided during a quarter that was found in previous quarters encounter data	Quarterly
ACA Enhanced Physician Payments	Report Format provided to the MCO's based on the previous quarters MCO encounter data.	Quarterly
MCO Withhold	Report template shared with the MCO to indicate quarterly withholding done to MCO's	Quarterly
Section 7.4.3.2		
FQHC RHC Wrap Payments Qtr	Current FQHC/RHC reports required for wrap payment process.	Quarterly
FQHC RHC Wrap Payments Annual	Current FQHC/RHC reports required for wrap payment process Annual Reconciliation.	Annually
Section 9		
Section 9.1.3.2		
Member Grievance Summary	Grievance Summary reporting required of the MCO.	Quarterly
Member Appeal Log	Appeal reporting required of the MCO.	Quarterly
Section 9.2.16		
Provider Dispute Log	Provider dispute reporting required of the MCO.	Quarterly
Section 10		
Section 10.9.1 through 10.9.1.4		
TPL Verification	Third Party Liability (TPL) Verification Report indicates those members the MCO indicates have third party insurance coverage. This report is submitted via the departments FTP site.	Monthly
TPL Cost Avoidance	TPL cost avoidance report indicates those claims that the MCO has cost avoided during the month.	Monthly
TPL COB Savings	TPL Coordination of Benefits (COB) report indicates those claims leading to coordination of benefits savings for the MCO.	Monthly
TPL Recoveries	Recoveries that the MCO have made as a result of research for members with potential or known third party coverage.	Monthly
TPL Casualty Cases	Any casualty cases that the MCO is aware are ongoing.	Monthly
Section 11		
Section 11.1.21 through 11.1.22		
Subcontract Submissions	Subcontracts and additional information on the principals with which the MCO will use to do Program Integrity (PI) investigations.	As Necessary
PI Fraud and Abuse Provider	Form for reporting potential provider abuse and fraud issues	As Necessary
PI Fraud and Abuse Member	Form for reporting potential member abuse and fraud issues	As Necessary
Fraud Notification	Form for reporting fraud notifications to the MCO	As Necessary
Complaint Case Notification	Form for reporting Complaint Cases to the MCO	As Necessary
DHHS BEOMB	Benefits of Explanation or Medical Benefits (BEOMB) form for reporting instances where a member indicates that they did not receive a service from a provider.	As Necessary
MCO Payment Suspension	Uniform letter for payment suspensions for providers operating with an MCO	As Necessary
Provider Suspensions	SharePoint templates for reporting provider suspensions	As Necessary
Provider Exclusions	SharePoint templates for reporting provider exclusions	As Necessary
Provider Terminations	SharePoint templates for reporting provider terminations	As Necessary
Section 11.2.12		
PI Written Compliance Plan	Specific Format not defined MCO can utilize any format it chooses to present the data. This report should be submitted directly to Program Integrity's SharePoint site.	Annually
Section 11.6		
Monthly MCO Fraud and Abuse	Monthly reporting of fraud and abuse. This report should be submitted directly to Program Integrity's SharePoint site.	Monthly
Termination Denial for Cause	Reporting of terminated providers. This report should be submitted directly to Program Integrity's SharePoint site.	Monthly
Quarterly MCO Fraud and Abuse	Quarterly reporting of fraud and abuse. This report should be submitted directly to Program Integrity's SharePoint site.	Quarterly
Section 13		
Table 13.1		
Claims Payment Accuracy	Report detailing monthly claim payment by the MCO.	Monthly
GME	Report detailing payment for Graduate Medical Education Providers and Institutions	Quarterly
Section 14		
Section 14.5		
Encounter Data	Current Milliman Layout	Daily, Weekly, Monthly
Encounter Submission Summary	Report detailing totals for monthly claims paid, accepted encounters, rejected encounters, and completeness percentage.	Monthly
Section 14.8		
FQHC RHC Wrap Payments Qtr	See section 7.4.3.2	Quarterly
FQHC RHC Wrap Payments Annual	See section 7.4.3.2	Annually
Section 14.10.8		
CRCS	Capitation Rate Calculation Sheet. Report detailing the units and amount paid per rate category.	Quarterly
Section 15		
Section 15.4 through 15.5		
HEDIS and CAHPS	NCQA defined	Annually
Section 15.7		
VOC	Value Oriented Contracting Form	Annually
Section 16		
Section 16.3.1		
QA GRID	As necessary for the MCO to ask questions of their account manager	As Necessary-Returned weekly to MCO

REPORT REQUIREMENTS

AS NECESSARY/DAILY

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Section 16		
Section 16.3.1		
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Section 2.1.10 Organizational Charts: There is no specific required format for this report. See Contract and P&P for details. Whenever changes are required, upload to the Required Submissions library in SharePoint.

Section 2.2.1.1 Personnel Resumes: There is no specific required format for this report. See Conract and P&P for details. Whenever changes are required, upload to the Required Submissions library in SharePoint.

Section 3.4.2: 834 Report Layout:
The 834 transcation file layout can be found at:
https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 3.13.2.1 – 3.13.2.4 Health Plan Initiated Member Disenrollment Form: This form should be completed when a MCO is requesting member disenrollment. The form can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools

Healthy Connections CHOICES

South Carolina Healthy Connections Choices
P.O. Box 8881
Columbia, SC 29202-8255
Ph: 1-877-552-4842 TTY/TDD Line: 1-877-552-4870

Health Plan-Initiated Disenrollment Request Form

Please complete and submit one form per member. Also include required documentation.

- Mail to: P.O. Box 8691, Columbia, SC 29202-9255
- Or fax to: 1-877-552-4672

Name of health plan: _____

Member Information:

- Name of member to be disenrolled: _____ (Last / First / Middle Initial)
- Birth date: / /_____
- Medicaid ID: _____
- Home address: _____
- Home phone: ( )_____

County: _____

Requested disenrollment date: / /

Reason for Request: Check the box that applies. Documentation must be submitted for any reason marked with an asterisk. Lack of sufficient documentation may result in denial.

- ☐ *Member has Medicare coverage
- ☐ Member has elected hospice
- ☐ Member has elected a home- and community-based waiver program
- ☐ *Member has been in a long-term care facility or a nursing home for more than 90 calendar days
- ☐ *Member is placed out of home, e.g., Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Psychiatric Residential Treatment Facility (PRTF)
- ☐ *Member is an inmate of a public institution
- ☐ *Member moved out of state or the health plan's service area
- ☐ *Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the health plan's ability to furnish services to the member or other members
- ☐ *Member has died
- ☐ *Other (please explain): _____

Authorized signature: _____ Date: / /

Print name: _____

South Carolina Healthy Connections Statement:

The health plan shall not discriminate against any South Carolina Healthy Connections member on the basis of their health status, need for health care services, or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion, or national origin.

The South Carolina Department of Health and Human Services (SCDHHS) will determine if the health plan has shown good cause to disenroll the above-named member. All decisions will be reflected on the monthly 834 file. Members have the right to appeal enrollment and disenrollment decisions with SCDHHS.

DisenrFrm042012

Nursing Home Web Notification: Please utilize the following link https://msp.scdhhs.gov/managedcare/site-page/reference-tools to notify SCDHHS of those members that have entered a nursing home.

Nursing Home Notification

Please complete the following form to notify the Division of Care Management of a Managed Care Organization enrolled beneficiary's admission to a nursing home.

Medicaid ID: *

Date of Birth: *

Beneficiary Last Name: *

Beneficiary First Name: *

Nursing Home Medicaid Provider ID: *

Nursing Home Facility Name: *

Nursing Home Admission Date: *

Submitter First/Last Name: *

Submitter Phone #: *

Submitter Email:

Comments:

Submit

Waiver/PACE Web Notification: Please utilize the following link https://msp.scdhhs.gov/managedcare/site-page/reference-tools to notify SCDHHS of those members that have entered a waiver.

Waiver Notification

Please complete the following form to notify the Division of Care Management of a Managed Care Organization enrolled beneficiary's admission to a waiver program.

Medicaid ID: *

Date of Birth: *

Beneficiary Last Name: *

Beneficiary First Name: *

Waiver Program: * Community Choices Waiver (CLTC)

Effective Date of Waiver Enrollment: *

Submitter First/Last Name: *

Submitter Phone #: *

Submitter Email:

Comments:

Submit

Hospice Web Notification: Please utilize the following link https://msp.scdhhs.gov/managedcare/site-page/reference-tools to notify SCDHHS of those members that have entered hospice.

Hospice Participation

Please complete the following form to notify the Division of Care Management of a Managed Care Organization enrolled beneficiary's election to participate in hospice.

Medicaid ID: *

Date of Birth: *

Beneficiary Last Name: *

Beneficiary First Name: *

Hospice Medicaid Provider ID: *

Name of Hospice : *

Submitter First/Last Name: *

Submitter Phone #: *

Submitter Email:

Comments:

Submit

Section 4.2.21:

Universal Medication Prior Authorization Form: This form is utilized for providers requesting medications and can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools.

South Carolina Healthy Connections

Prior Authorization Request Form: Medications

Please type or print neatly. Incomplete and illegible forms will delay processing.

I. Provider Information

Prescriber name	NPI #
Prescriber specialty	Phone
Prescriber address	
Office contact name	Fax
Pharmacy name	Pharmacy phone

II. Member Information

Member name	Today's date
Member plan ID #	Date of birth
Drug allergies	
Plan name and fax for form submission	

III. Drug Information (one drug per request form)

Drug name	Drug strength	Dosage form	Dosage interval	Quantity per day
Diagnosis relevant to this request				ICD-9 code
Expected length of therapy				Number of refills

IV. Drug History for this Diagnosis

A. Is the prescription for a drug to be administered in the office or for the member to take at home? office home

B. Is the member currently treated on this drug? Yes: how long? _____ [go to item C] No [skip items C and D; go to item E]

C. Is this request for continuation of a previous approval? Yes [go to item D] No [skip item D; go to item E]

D. Has strength, dosage or quantity required per day increased or decreased?

Yes [go to item E] No [skip item E; indicate rationale in Section V and submit form]

E. Please indicate previous treatments and outcomes with other medications below.

Drug name	Strength	Directions	Dates of therapy	Reason for failure or discontinuation

V. Rationale for Request and Pertinent Clinical Information (attach additional sheets if more space is needed)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	
Prescriber/Authorized Representative signature	Date

Plan Fax Numbers

Absolute Total Care	1.866.399.0929	First Choice by Select Health	1.866.610.2775
Advicare	1.866.255.7569	Molina Healthcare of SC	1.855.571.3011
BlueChoice HealthPlan Medicaid	1.866.807.6241	Wellness of SC	1.866.354.8709
FFS Medicaid	1.888.603.7696		

Rev. 04192013

Makena/17-P Prior Authorization Form: This form is utilized for providers requesting 17-P and/or Makena and can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools

Universal 17-P Authorization Form

***Fax the COMPLETED form OR call the plan with the requested information.**

☐Absolute Total Care	☐BlueChoice HealthPlan	☐First Choice by Select Health	☐WellCare Health Plan, Inc.
P: 866-433-6041 F: 866-918-4451	P: 866-902-1689 F: 800-823-5520	P: 888-559-1010 x51042 F: 866-533-5493	P: 888-588-9842 F: 866-354-8709

☐Advicare	☐Molina Healthcare, Inc.
P: 888- 781-4371 F: 888- 781-4316	P: 855- 237-6178 F: 855- 571-3011

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

☐Pregnancy Information and History

G___ T___ P___ A___ L___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest ☐Yes ☐No Experiencing Preterm Labor ☐Yes☐ No
(Home administration available if on bed rest)

☐Singleton Pregnancy ☐Multiple Pregnancy

At least 16 weeks gestation ☐Yes ☐No** Major Fetal or Uterine Anomaly ☐Yes ☐No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐Yes ☐No

Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐Yes ☐No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐Yes ☐No

Medication Allergies _____ ☐No known drug allergies

Other Pertinent Clinical Information:_____

_____

☐Pharmacy Information

☐Ship to patient's home address End Date of Service _____

☐Ship to provider's address End Date of Service _____

Shipping Preference: ☐Regular Mail ☐Ground ☐Overnight

Universal PA Form Synagis: Required for providers requesting Synagis can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools.

***Fax the COMPLETED form or call the plan with the requested information.**

Absolute Total Care	Advicare	BlueChoice HealthPlan Medicaid	First Choice	Molina Healthcare	WellCare Health Plan
P: 866-433-6041 F: 855-865-9469	P: 888-781-4371 F: 888-781-4316	P: 866-902-1689 F: 800-823-5520	P: 866-610-2273 F: 866-610-2775	P: 855-237-6178 F: 855-571-3011	P: 888-588-9842 F: 866-354-8709

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

STRENGTH: ☐ 50 mg (NDC 60574411401) **QUANTITY:** **PA START DATE**

☐ 100 mg (NDC 60574411301) **QUANTITY** _____ **PA START DATE** _____

NAME OF DISPENSING PHARMACY: _____ **NPI NUMBER:** _____

PHONE NUMBER: – – **FAX NUMBER:** – –

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****

1. **What was the patient's gestational age at birth, current weight, and gender?**

_____weeks _____days

_____kg or _____lb

☐ Male ☐ Female

2. **Does the patient have Chronic Lung Disease of Prematurity (Formerly called bronchopulmonary dysplasia)** ☐ Yes (go to question 3) ☐
3. **Did the patient receive oxygen immediately following birth?** ☐ Yes (go to question 4) ☐ No (go to question 6)
4. **Please indicate the % oxygen received, date received, and the duration of treatment**:
5. **Please indicate if patient is receiving any of the following respiratory support therapies on a daily basis:**
   - ☐ Oxygen Most recent date _____
   - ☐ Systemic corticosteroids Most recent date _____
   - ☐ Diuretics Most recent date _____
   - ☐ Bronchodilator Most recent date _____
6. **Does the patient have a diagnosis of Cystic Fibrosis?** ☐ Yes (submit documentation of pulmonary & nutritional status) ☐ No
7. **Please indicate if patient has any of the following:**

☐ Anatomic Pulmonary Abnormality, specify: _____ ☐ Neuromuscular Disorder, specify:

☐ Congenital anomaly that impairs the ability to clear secretions, specify:

8. Please indicate if patient has any of the following:

☐ HIV ☐ Cancer, receiving chemotherapy ☐ Organ transplant receiving immunosuppressant therapy

☐ Other medical condition that is severely immunocompromising patient, (e.g. Children younger than 24 months who will be profoundly immunocompromised during the RSV season) please specify: _____

9. Has this patient received a heart transplant? ☐ Yes (date: ☐ No

10. Does patient have hemodynamically significant congenital heart disease? ☐ Yes (please indicate) ☐ No

☐ Acyanotic heart disease (specify: _____)

☐ Cyanotic heart disease (specify: _____; Name of Pediatric Cardiologist:_____)

☐ Pulmonary Hypertension ☐ Other:

_____

11. Will this patient's congenital heart disease require cardiac surgery? ☐ Yes ☐ No

12. Please list any medications that may be used:

☐ Ace-Inhibitor/ARB Most recent date administered: _____

☐ Diuretic Most recent date administered: _____

☐ Beta-blocker Most recent date administered: _____

☐ Digoxin Most recent date administered: _____

☐ Other cardiovascular medications (specify): _____

Please note any other information pertinent to this PA request: _____

_____

_____

_____

_____

_____ _____

Prescriber Signature (Required) ***Date***

*(**On behalf of the Prescriber or Pharmacy Provider, I **certify that the information stated above is a true statement, made for the purposes of inducing SC Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that this document and any attached materials will be retained for the purposes of possible future audit(s).*

Section 4.3.2 – 4.3.4 Additional Services Form: If an MCO would like to provide additional services beyond the core benefit please complete the form below. All field definitions are also provided below. MCO's are encouraged to add additional information as necessary to support their request.

Required Fields for Additional Services Evaluation

Primary Sponsor	Requestor
Member Additional Service Request	Title/subject matter of this additional service request.
Request Submission Date	Date this request is submitted to SC DHHS.
Background and Rationale	Complete description of problem statement and reason for request, as well as rationale supporting the selection of this specific additional service.
Objectives	Statement of what the MCO is trying to accomplish with this additional service request.
Exploratory	Measureable outcomes that the MCO expects as a result of providing the additional service. What will the MCO measure to evaluate the efficacy of this intervention?
Duration of Study	Measurement period. (Start and end date of evaluation period.)
Comparator	Provide baseline data of all measurements described in the exploratory section with this request. At completion of the measurement period, the MCO must provide post-intervention performance data.
Subject Population/Comparator	The population that you are targeting for this intervention. Be very specific, examples include: Age grouping/dates of enrollment/ diagnoses/ procedural codes.
Discontinuation Criteria	Define reasons why someone may be removed from the study. Example- Patients who lose Medicaid eligibility for a period lasting not longer than 180 days, or six months.

Section 4.3.2 – 4.3.4 Additional Services Form: Additional Service Evaluation Form (Blank)

Primary Sponsor	
Member Additional Service Request	
Request Submission Date	
Background and Rationale	
Objectives	
Exploratory	
Duration of Study	
Comparator	
Subject Population/Comparator	
Discontinuation Criteria	

Section 4.8 Member Incentive Form: If an MCO would like to utilize a member incentive please complete the form below. All field definitions are also provided below. MCO's are encouraged to add additional information as necessary to support their request.

Required Fields for Incentive Evaluation

Primary Sponsor	Requestor
Member Incentive Request	Title/subject matter of this request above $25.00 for unique study regarding member incentives.
Request Submission Date	Date this request is submitted to SC DHHS.
Background and Rationale	Complete description of problem statement and reason for request, as well as rationale supporting the selection of this specific incentive.
Objectives	Statement of what the MCO is trying to accomplish with this incentive request.
Exploratory	Measureable outcomes that the MCO expects as a result of providing the incentive. What will the MCO measure to evaluate the efficacy of this intervention?
Duration of Study	Measurement period. (Start and end date of evaluation period.)
Comparator	Provide baseline data of all measurements described in the exploratory section with this request. At completion of the measurement period, the MCO must provide post-intervention performance data.
Subject Population/Comparator	The population that you are targeting for this intervention. Be very specific, examples include: Age grouping/dates of enrollment/ diagnoses/ procedural codes.
Discontinuation Criteria	Define reasons why someone may be removed from the study. Example- Patients who lose Medicaid eligibility for a period lasting not longer than 180 days, or six months.

Section 4.8 Member Incentive Form: Incentive Evaluation Form (Blank)

Primary Sponsor	
Member Incentive Request	
Request Submission Date	
Background and Rationale	
Objectives	
Exploratory	
Duration of Study	
Comparator	
Subject Population/Comparator	
Discontinuation Criteria	

Section 5.5.1.1: This form is also available on the SCDHHS website at https://msp.scdhhs.gov/managedcare/site-page/reference-tools it is labeled Universal Prior Authorization Form. Providers need to complete this form in cases where a newborn is being seen out of network with an MCO. Please see the contract for additional details regarding newborn Medicaid services.

Universal Newborn Prior Authorization Form - Pediatric Offices

Out-of-network pediatric providers must provide this information to obtain an authorization for services rendered in the office during the first 60 days after discharge. Authorization should be requested by close of the next business day. For questions, contact the plan at the associated phone number.
***Fax the COMPLETED form OR call the plan with the requested information.**

☐ Absolute Total Care	☐ Advicare	☐ BlueChoice HealthPlan Medicaid	☐ First Choice by Select Health	☐ Molina HealthCare of SC	☐ WellCare of SC
P: 1.866.433.6041 F: 1.866.918.4451 www.absolutetotalcare.com	P: 1.888.781.4371 F: 1.888.781.4316 www.advicarehealth.com	P: 1.866.902.1689 F: 1.800.823.3520 www.bluechoicescmedicaid.com	P: 1.888.559.1010 F: 1.866.368.4562 www.selecthealthofsc.com	P: 1.855.237.6178 F: 1.855.571.3011 www.molinahealthcare.com	P: 1.888.588.9842 F: 1.877.431.8859 www.wellcare.com

Patient's name (first, middle, last)			DOB
Street address, apt. number		City, State, Zip	
Home phone	Mobile phone	Medicaid number	MCO ID number
Mom's name (first, middle, last)		Mom's Medicaid number	Mom's SSN

SECONDARY COVERAGE

Plan		ID number	Group number
Policy holder	DOB	Relationship to patient	Employer

☐ EPSDT and Immunization				
☐ 99381 (EPSDT new)		☐ 99391 (EPSDT established)	☐ 1 visit	☐ 2 visits
☐ 90471	DOS	Immunization administered		
☐ 90472	DOS	Immunization administered		
☐ 90473	DOS	Immunization administered		

☐ E/M Non-EPSDT					
☐ CPT	Dx	DOS	☐ CPT	Dx	DOS

☐ Labs	CLIA Certificate Number:				
☐ CPT	DOS	☐ CPT	DOS	☐ CPT	DOS
☐ CPT	DOS	☐ CPT	DOS	☐ CPT	DOS

☐ Other					
☐ 17250	DOS	☐ 54160	DOS	☐ 96150	DOS
☐ 51701	DOS	☐ 94640	DOS	☐ 96152	DOS
☐ 54150	DOS	☐ 94760	DOS	☐ 97802	DOS
☐ CPT	DOS	☐ CPT	DOS	☐ CPT	DOS

Practice name			Practice NPI number
Attending physician (last name, first name)			Physician NPI number
Contact person		Phone	Fax
Plan point of contact	Date plan called	Time of call	Plan reference/confirmation number

For MCO use only.		
☐ Approved ☐ Denied	Authorization number	Date of notification to pediatric office
Reviewer name	Reviewer title	Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

Universal Newborn Authorization Form 1.2014

Section 7.3.1.1 Premium Payment Adjustments: The following report will be sent to MCO's to retroactively reconcile premiums paid at a previously approved rate in months where a new premium has been created for payment but not yet implemented within the Medicaid processing system.

South Carolina
Department of Health and Human Services
Bureau of Reimbursement Methodology and Policy

Rate Adjustment Analysis
Member Months
Reporting for (date)

Rate Category		Month	Total	Previous Rates	Present Rates	Variance	Adjusted Capitated Payments
0-2 months old	AH3						
3-12 months old	AI3						
1-6 M&F	AB3						
7-13 M&F	AC3						
14-18 M	AD1						
14-18 F	AD2						
19-44 M	AE1						
19-44 F	AE2						
45+ M&F	AF3						
Maternity Kicker any age	NG2						
SSI w/o Medicare (0-18)	SO3						
SSI w/o Medicare (19-up)	SP3						
OCWI F	WG2						
Foster Care	FG3						
Total Retro Rate Adj		0	0				0.00
Total Adjustment							
	File:				Date:		
	Subfile:				Prepared:		
	Path:				Reviewed:		
	Source:						

Section 11.1.21 through 11.1.22 Provider and Member Fraud and Abuse Referral Forms: Below are the instructions and forms the MCO should send when they suspect provider and/or member fraud and abuse.

Provider Fraud & Abuse Referral Form for Managed Care Organizations

Send To: **Division of Program Integrity** (c/o Betsy Corley)
Via: **SharePoint**

Form to be completed and submitted using Share Point.
You MUST notify Betsy Corley that the form has been submitted in SharePoint.
If you have not received receipt in 5 business days, please follow-up to assure it was received.

REFERRAL TYPE		
☐ **Fraud/Abuse** Reporting suspected fraud or abuse case	**Termination for Cause:** ☐ **MCO Initiated (NEW)** ☐ **Acknowledge Medicaid Initiated TFC/Exclusion** Reporting a TFC provider NEW = TFC taken by MCO Acknowledging Medicaid's action = Acknowledge receipt of and action taken	☐ **Credentialing Denied for Cause** Providers Application Denied for Cause by MCO
	☐ **TIP** **Complete Sections A, B and F. Attach any supporting documentation** Used by the MCO to notify DHHS regarding possible issues with a provider.	

Section A REFERRAL INFORMATION							
Date of Referral	Select Value						
	Date MCO is making this referral to SCDHHS PI						
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.						
MCO Name:	Select Value						
	Name of MCO making the referral.						
	Drop-Down Box. Select the Name of MCO making referral. If not listed, select OTHER and write it in.						
Person Reporting:	Name of MCO individual making the referral						
Tel #:	Tele# of above listed MCO individual making the referral						
Investigator/Reviewer:	Name of MCO Investigator/Reviewer working the case						
Tel #:	Tele# of above listed MCO Investigator/Reviewer working the case						
E-Mail:	E-Mail of above listed MCO Investigator/Reviewer working the case						
Section B PROVIDER INFORMATION							
Provider/Facility Name:	Name of Provider or Facility being referred by the MCO						
Provider's MCO ID #:	Provider's MCO ID as assigned by the MCO						
Address:	Provider's Street address (location under review)						
City:	City for above address	**State:**	State for above address	**Zip:**	Zip for above address	**County:**	Select a Value
	COUNTY: Drop-Down Box. Select the County for the Provider Address listed above.						
Provider NPI(s):	Provider's NPI number(s)						
Provider SSN/EIN(s):	SSN: XXX-XX-____ Provider's SSN (ONLY USE THE LAST 4 DIGITS) or EIN used for billing claims						

Ver 2 [Type here] 8/1/15

Provider Type:	Select Value
	Drop-Down Box. Select the Provider Type for Provider being referred. If not listed, select OTHER and write it in.
☐ **Group** or ☐ **Individual**	Is Provider being referred a Group or Individual practice
Section C	**CASE/REVIEW INFORMATION**
Basis for Referral:	Select Value
	Drop-Down Box. Select Referral Reason. If not listed, select OTHER and write it in.
Dates of Service Reviewed/Questioned: START DATE	Select Value
DOS for which a review was conducted. Or time frame given in allegation	First date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.
END DATE	Select Value
	Last date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.
Total Amount Paid To Provider For Review Period:	$ Total of ALL CLAIMS paid during above period
Estimated Dollar Value of Fraud/Abuse:	$ Of the above Total, estimated dollars associated with possible fraud and abuse

Allegation: Source of allegation (source name, phone #), reason for making allegation and the allegation.

Should include:

- Allegations – as reported by a Complaint
- Report names – if identified thru data mining activities
- Other information as needed to explain why the Provider was reviewed

Summary of Investigative Results: (or see attached Investigative Report)

This should be a synopsis of the investigation conducted by the MCO reviewer, to include:

- Data reviewed – what stands out, ex specific Procedure Codes
- Interviews with the Provider and/or Members and Contact Information
- On-site visit
- Overpayments Determined / Letters Sent
- Current Status of the case
- Data in Excel format and not PBA

- The Allegation should detail why the Provider is being referred for possible fraud/abuse.

- What made someone file a Complaint
- Why did he stand out on a report

- The Summary should detail what action the MCO reviewer has taken that substantiates the Allegation.
  - Reports
    - Exception reports
    - Time Bandit reports
    - Peer Comparisons
    - Trending reports
  - Interviews conducted and the relevant information to substantiate the Allegation.
  - On-site visits and the results
  - If an overpayment has been determined by the MCO for the claims in question
  - Has the MCO sent a letter to the Provider requesting payment
  - What is the current status?
    - Awaiting DHHS to take action
    - Awaiting the Provider to respond to a letter
    - Awaiting a Provider recovery
- The Summary should give the PI reviewer enough information to run data sets and look for the same pattern, or lack of.
- The Summary will aid the PI reviewer on how best to conduct her review in an effort to substantiate the Allegation and prepare the case for a MFCU referral.

Section D	Provide copies of supporting documentation; such as:	
☐ Credentialing File	☐ Initial Complaint	☐ MCO Administrative Actions
☐ Provider Contract with MCO	☐ Applicable MCO Policy	☐ Patient Records
☐ Any Correspondence with Provider	☐ Record of Preliminary Investigation	☐ Data Analytics (If ID'ed Through Data Mining)
Please provide copies of above mentioned supporting documentation. Check those that are attached to the Referral.		
***Notes:** If the file is large and/or will be delivered at a later date, ex via the PI Portal, please document here in the *Notes section. *Notes can be used for any information related to documents and attachments.		
Section E	**TERMINATION FOR CAUSE/DENIAL INFORMATION**	
This Section is for reporting new MCO Provider Terminations and Denials for Cause. In addition, if SCDHHS has initiated a TFC/Exclusion, the MCO will use this section to responding. For example, they have terminated as a result of DHHS action, or they do not have that provider in network.		

☐ Participating Provider	☐ Non-Participating Provider
Is the Provider being referred a participant in the MCO Network	
☐ Termination for Cause	MCO Terminated the Provider for Cause
Termination Date:	Select Value
	Date the Provider was Terminated from the MCO Network
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.
Terminated For Cause Reason:	Select Value
	Drop-Down Box. Select the Reason for TFC. If not listed, select OTHER and write it in.
☐ PROVIDER IS NOT IN NETWORK. No action taken by MCO. Check **ONLY IF** responding to a Medicaid initiated Exclusion/Termination and the provider is not in your Network	
CHECK THIS BOX ONLY IF: SCDHHS has initiated a TFC and the MCO is unable to terminate because this provider is not in their network	
☐ Credentialing Denied for Cause	MCO Denied the Providers Enrollment Application for Cause
Denial Date:	Select Value
	Date the Provider's Application was Denied by the MCO
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.
Denial Reason:	Select Value
	Drop-Down Box. Select the Denial Reason. If not listed, select OTHER and write it in.
*Notes: *Notes can be used for any information related to Termination for Cause, Enrollment Denials and Exclusions.	

Section F TIP INFORMATION
Summary: : Provide all pertinent information as to why this provider is being referred. For example, loss of license, excluded in another state, etc... A TIP does not mean that the MCO has an active Complaint or Case against the provider.

PROVIDER FRAUD AND ABUSE REFFERAL KEY:

Section A

MCO Name:

- Select a Value
- Absolute Total Care HM2200
- Advicare HM3400
- Blue Choice HM3200
- Molina HM3600
- Select Health HM1000
- Well Care HM3800
- Other:

Section B

County:

- Select a Value
- Abbeville 01
- Aiken 02
- Allendale 03
- Anderson 04
- Bamberg 05
- Barnwell 06
- Beaufort 07
- Berkeley 08
- Calhoun 09
- Charleston 10
- Cherokee 11
- Chester 12
- Chesterfield 13
- Clarendon 14
- Colleton 15
- Darlington 16
- Dillon 17
- Dorchester 18
- Edgefield 19
- Fairfield 20
- Florence 21
- Georgetown 22
- Greenville 23
- Greenwood 24
- Hampton 25
- Horry 26
- Jasper 27
- Kershaw 28
- Lancaster 29
- Laurens 30
- Lee 31
- Lexington 32
- McCormick 33
- Marion 34
- Marlboro 35
- Newberry 36
- Oconee 37
- Orangeburg 38
- Pickens 39

PROVIDER FRAUD AND ABUSE REFFERAL KEY (cont.):

Provider Type:

Select a Value
00 Nursing Home
01 Inpatient Hospital
02 Outpatient Hopsital
10 Mental Health and Rehab
16 EPSDT
19 Other Medical Professional
20 Physician
22 Medical Clinics (includes RHC/FQHC)
30 Dentist
32 Optician
33 Optometrist
35 Podiatrist
37 Chiropractor
60 Home Health/Hospice
61 CLTC
70 Pharmacy
76 DME
80 Lab
81 X-Ray
82 Psychologist
99 Other:
04 Audiologist
06 Midwife
25 Nurse Anesthetist
84 Speech Therapist
85 Physical Therapist
86 Nurse Practitioner
87 Occupational Therapist
PC Licensed Professional Counselor
SW Licensed Independent Social Worker

Section C

Basis for Referral:

Select a Value
A: No documentation for service
B: Manufactured or altered documentation or forged signatures
C: Unapproved marketing/Recruitment of Patients
D: Use of another provider's ID by Excluded/Terminated individual
E: Billing for services, supplies or equipment that are not rendered or used for Medicaid members
F: Excessive cost or number of claims
G: Material misrepresentation of information on the claim
H: Billing unreasonable or improbable # units or services (Time Bandit)
I: Billing unreasonable or excessive amount of supplies or supplies clearly unsuitable to patients needs
J: Procedure codes/services do not correspond with provider type
K: Procedure code/ services/ #units not supported by member's diagnosis
L: Repeated patterns of up-coding and/or unbundling that result in large overpayment to provider
M: Unexplainable, significant spikes in claims volumes and reimbursement
N: Billing for numerous diagnostics with no documentation for medical necessity
O: Terminated for Cause
P: Confirmed BEOMB Complaint that Services were not delivered
Q: Other:

PROVIDER FRAUD AND ABUSE REFFERAL KEY (cont.):

Section E

Terminated For Cause Reason:

Select a Value
T1: Person with 5% or greater ownership & has been convicted of a crime related to Medicaid/Medicare or Title XXI in past 10 years
T2: Provider terminated on or after January 1, 2011 by Medicare or another states' Medicaid or CHIP program
T3: Provider/person with an ownership or control interest or who is an agent or managing employee of the provider fail to submit timely accurate information
T4: Provider fails to permit access to provider's location for site visits
T5: Provider has falsified information provided on application
T6: Cannot verify the identity of the provider
T7: Provider fails to comply with the terms of the enrollment agreement
T8: Provider has contract with SCDHHS and has either failed to produce required deliverables or not in compliance with contract and contract terminated
T9: Provider has not repaid an outstanding debit or recoupment identified through a Program Integrity review
T10: Provider's license is inactive/suspended/revoked
T11: Provider has been terminated by a Managed Care Organization for reasons due to Fraud or Quality of Care
T12: Provider's license is on probation
T13: Excluded Provider from Medicare/Medicaid Programs
Other:

Denial Reason:

Select a Value
D1: Person with 5% or greater ownership & has been convicted of a crime related to Medicare/Medicaid or Title XXI in past 10 years
D2: Provider terminated on or after January 1, 2011 by Medicare or another states' Medicaid or CHIP program
D3: Provider/person with an ownership or control interest or who is an agent or managing employee of the provider fail to submit timely accurate information
D4: Provider or person with 5% or greater direct or indirect ownership interest fails to submit fingerprints within 30 days
D5: Provider fails to permit access to provider's location for site visits
D6: Provider has falsified information provided on application
D7: Cannot verify the identity of the provider
D8: Provider's license is inactive/suspended/revoked
D9: Provider fails to meet credentialing, certification and/or additional licensure requirements as specified by DHHS
D10: Provider fails to sign/or send in contract within required time limits
Other:

Provider Fraud & Abuse Referral Form for Managed Care Organizations

Send To: **Division of Program Integrity (c/o Betsy Corley)**
Via: **SharePoint**

REFERRAL TYPE		
☐ **Fraud/Abuse**	**Termination for Cause:** ☐ **MCO Initiated (NEW)** ☐ **Acknowledge Medicaid Initiated TFC/Exclusion**	☐ **Credentialing Denied for Cause**
	☐ **TIP** **Complete Sections A, B and F. Attach any supporting documentation**	

Section A REFERRAL INFORMATION	
Date of Referral	Select Value
MCO Name:	Select Value
Person Reporting:	
Tel #:	
Investigator/Reviewer:	
Tel #:	
E-Mail:	

Section B PROVIDER INFORMATION							
Provider/Facility Name:							
Provider's MCO ID #:							
Address:							
City:		**State:**		**Zip:**		**County:**	Select a Value
Provider NPI(s):							
Provider SSN/EIN(s):	SSN: XXX-XX- / EIN:						
Provider Type:	Select Value						
☐ **Group or** ☐ **Individual**							

Section C CASE/REVIEW INFORMATION		
Basis for Referral:	Select Value	
Dates of Service Reviewed/Questioned:	**START DATE**	Select Value
	END DATE	Select Value
Total Amount Paid To Provider For Review Period:		$
Estimated Dollar Value of Fraud/Abuse:		$

Allegation: Source of allegation (source name, phone #), reason for making allegation and the allegation.

Summary of Investigative Results: (or see attached Investigative Report)

Section D	**Provide copies of supporting documentation; such as:**	
☐ Credentialing File	☐ Initial Complaint	☐ MCO Administrative Actions
☐ Provider Contract with MCO	☐ Applicable MCO Policy	☐ Patient Records
☐ Any Correspondence with Provider	☐ Record of Preliminary Investigation	☐ Data Analytics (If ID'ed Through Data Mining)
***Notes:**		

Section E	**TERMINATION FOR CAUSE/DENIAL INFORMATION**
☐ **Participating Provider**	☐ **Non-Participating Provider**
☐ **Termination for Cause**	
Termination Date:	Select Value
Terminated For Cause Reason:	Select Value
☐ **PROVIDER IS NOT IN NETWORK. No action taken by MCO.** Check **ONLY IF** responding to a Medicaid initiated Exclusion/Termination and the provider is not in your Network	
☐ **Credentialing Denied for Cause**	
Denial Date:	Select Value
Denial Reason:	Select Value
***Notes:**	

Section F TIP INFORMATION
Summary:

Member Fraud & Abuse Referral Form for Managed Care Organizations

Send To: Division of Program Integrity (c/o Betsy Corley)
Via: SharePoint

Form to be completed and submitted using Share Point.
You MUST notify Betsy Corley that the form has been submitted in SharePoint.
If you have not received receipt in 5 business days, please follow-up to assure it was received.

Section A REFERRAL INFORMATION							
Date of Referral	Select Value						
	Date MCO is making this referral to SCDHHS PI						
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.						
Person Reporting:	Name of MCO individual making the referral						
MCO Name:	Select Value						
	Name of MCO making the referral.						
	Drop-Down Box. Select the Name of MCO making referral. If not listed, select OTHER and write it in.						
Tel #:	Tele# of above listed MCO individual making the referral						
E-Mail:	E-mail of above listed MCO individual making referral						
Section B MEMBER INFORMATION							
Name: (First, MI, Last)	Name of Member being referred First Name, Middle Initial, Last Name						
Medicaid ID #:	Member's Medicaid Number as assigned by SCDHHS						
Address:	Member's Street address (residence location)						
City:	City for above address	State:	State for above address	Zip:	Zip for above address	County:	Select Value
	COUNTY: Drop-Down Box. Select the County for the Member Address listed above.						
Plan Enrollment Date:	Select Value						
	Date Member was enrolled in the MCO Plan						
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.						
Section C CASE/REVIEW INFORMATION							
Basis for Referral:	Select Value						
	Reason the Member is being referred						
	Drop-Down Box. Select the Basis for Referral. If not listed, select OTHER and write it in.						
Nature of Complaint:	☐ FINANCIAL OR PHYSICAL ABUSE ☐ MEDICAID ELIGIBILITY FRAUD ☒ DRUG DIVERSION ☒ OTHER _____						
	Is Member being abused by someone in regards to their money or health?						
	Is Member's eligibility status in question? Is Member selling prescriptions, sharing Medicaid card, etc?						
	Is Member being reported for another reason? (You have limited space to write other reason)						

Time Frame/Dates of Service Reviewed: START DATE	Select Value
DOS for which a review was conducted. Or time frame given in allegation	First date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.
END DATE	Select Value
	Last date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.

Allegation: Source of allegation (source name, phone #), reason for making allegation and the allegation.
Should include:

- Allegations – as reported by a Complaint
- Report names – if identified thru data mining activities
- Other information as needed to explain why the Member is suspected of fraud
- Name and phone # of source reporting allegation

Summary of Investigative Results:

This should be a synopsis if an investigation conducted by the MCO reviewer, to include:

- Data reviewed – what stands out
- Interviews with the Member and Contact Information
- Letters Sent
- Current Status of the case

Section D PROVIDE COPIES OF SUPPORTING DOCUMENTATION WHERE APPLICABLE

***Notes:**
Provide supporting documentation, to include the original Complaint/Allegation, interviews or enrollment forms.
Please note the enclosed attachments.

Send

MEMBER FRAUD AND ABUSE REFFERAL KEY:

Section A
MCO Name:

- Select a Value
- Absolute Total Care HM2200
- Advicare HM3400
- Blue Choice HM3200
- Molina HM3600
- Select Health HM1000
- Well Care HM3800
- Other:

Section B
County:

- Select a Value
- Abbeville 01
- Aiken 02
- Allendale 03
- Anderson 04
- Bamberg 05
- Barnwell 06
- Beaufort 07
- Berkeley 08
- Calhoun 09
- Charleston 10
- Cherokee 11
- Chester 12
- Chesterfield 13
- Clarendon 14
- Colleton 15
- Darlington 16
- Dillon 17
- Dorchester 18
- Edgefield 19
- Fairfield 20
- Florence 21
- Georgetown 22
- Greenville 23
- Greenwood 24
- Hampton 25
- Horry 26
- Jasper 27
- Kershaw 28
- Lancaster 29
- Laurens 30
- Lee 31
- Lexington 32
- McCormick 33
- Marion 34
- Marlboro 35
- Newberry 36
- Oconee 37
- Orangeburg 38
- Pickens 39

MEMBER FRAUD AND ABUSE REFFERAL KEY (cont.):

Section C

Basis for Referral:

Select a Value
1 Suspicion that member submitted a false application for Medicaid
2 Provided false or misleading information about family group, income, assets, resources or other information to fraudulently gain eligibility for benefits
3 Shared or lent their Medicaid card to other individuals
4 Sold or bought a Medicaid card
5 Diverted for re-sale prescription drugs, medical supplies or other benefits
6 Obtained Medicaid benefits not entitled to through other fraudulent means
7 Other:

Member Fraud & Abuse Referral Form for Managed Care Organizations

Send To: Division of Program Integrity (c/o Betsy Corley)
Via: SharePoint

Section A REFERRAL INFORMATION							
Date of Referral	Select Value						
Person Reporting:							
MCO Name:	Select Value						
Tel #:							
E-Mail:							
Section B MEMBER INFORMATION							
Name: (First, MI, Last)							
Medicaid ID #:							
Address:							
City:		State:		Zip:		County:	Select Value
Plan Enrollment Date:	Select Value						
Section C CASE/REVIEW INFORMATION							
Basis for Referral:	Select Value						
Nature of Complaint:	☐ FINANCIAL OR PHYSICAL ABUSE ☐ MEDICAID ELIGIBILITY FRAUD ☐ DRUG DIVERSION ☒ OTHER _____						
Time Frame/Dates of Service Reviewed: START DATE	Select Value						
END DATE	Select Value						
Allegation: Source of allegation (source name, phone #), reason for making allegation and the allegation. Summary of Investigative Results:							
Section D PROVIDE COPIES OF SUPPORTING DOCUMENTATION WHERE APPLICABLE							
*Notes:							

FRAUD Notification Form from SC DHHS PI

To: MCO PI Compliance Officer
From: SCDHHS, PI, Betsy Corley

Form to be delivered to the MCO PI Compliance Officer
From the MCO PI Coordinator (or PI Supervisor)
This form will be used by DHHS to notify the MCOs of Providers being referred to MFCU for potential fraud.

MCO RETURN TO:

Upload completed FORM to the PI Share Point site, under MCO folder, Shared Documents
This FORM should be completed by the MCO and uploaded to the MCO PI Share Point Site under the MCO Name, Share Documents Folder.

NOTIFICATION TYPE							
☐ Fraud Suspected Fraud, Referral to MFCU warranted *COORDINATION REQUIRED RESPOND BY _____ * _____							
Check Box indicates DHHS PI is referring the Provider to MFCU for suspected fraud. This Notification is a coordination between DHHS PI and the MCOs. Every effort will be made to combine all reviews into one case for a MFCU referral. *Please respond by indicated date so that DHHS can move forward with the MFCU referral.							
Section A NOTIFICATION INFORMATION							
Date of Referral	Select Value						
	Date DHHS PI sends this Notification to the MCOs						
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.						
MCO's Identified:	☐ Absolute (ATC) HM2200		☐ Blue Choice HM 3200		☐ Select Health HM1000		
	☐ Advicare HM3400		☐ Molina HM3600		☐ Well Care HM3800		
	Check indicates all MCOs who will receive this Notification. Check could indicate specific MCO(s), or it could serve as multi-notification.						
Person Reporting:	Name of DHHS PI individual making the notification						
Tel #:	Tele# of above listed DHHS PI individual making the notification						
Investigator/Reviewer:	Name of DHHS PI Investigator/Reviewer working the case The DHHS Reviewer will monitor the site to make sure they receive all MCO responses.						
Tel #:	Tele# of above listed DHHS PI Investigator/Reviewer working the case						
E-Mail:	E-Mail of above listed DHHS PI Investigator/Reviewer working the case						
Section B PROVIDER INFORMATION							
Provider/Facility Name:	Name of Provider or Facility being referred by DHHS PI to MFCU						
Provider's Medicaid ID #:	Provider's DHHS ID as assigned by DHHS						
Address:	Provider's Street address (location under review)						
City:	City for above	State:	State for above	Zip:	Zip for above	County:	Select Value

	address		address		address		
	COUNTY: Drop-Down Box. Select the County for the Provider Address listed above.						
Provider NPI(s):	Provider's NPI number(s)						
Provider SSN/EIN(s):	SSN: XXX-XX-____ Provider's SSN (ONLY USE THE LAST 4 DIGITS) or EIN used for billing claims						
Provider Type:	Select a Value						
	Drop-Down Box. Select the Provider Type for Provider being referred. If not listed, select OTHER and write it in.						
☐ Group or ☐ Individual	Is Provider being referred a Group or Individual practice						
Section C CASE/REVIEW INFORMATION							
Basis for Referral:	Select a Value						
	Drop-Down Box. Select Notification Reason. If not listed, select OTHER and write it in.						

Dates of Service Reviewed/Period in Question: START DATE	Select Value
DOS for which a review was conducted. Or time frame given in allegation	First date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.
END DATE	Select Value
	Last date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.

Summary of Investigative Results:

This should be a synopsis of the investigation conducted by the DHHS PI reviewer, to include:

- Data reviewed – what stands out, ex specific Procedure Codes
- Interviews with the Provider and/or Members
- On-site visit
- Overpayments Determined / Letters Sent
- Current Status of the case

MCOs RESPONSE TO THE PI FRAUD NOTIFICATION:

Section used by the MCO to respond to the FRAUD NOTIFICATION Request.
For example: not a Network Provider, or details of an ongoing case.
This form will help DHHS coordinate with all MCOs just prior to our referring the case to MFCU.

DATE: / /

FRAUD Notification Form from SC DHHS PI

Should be the Date the MCO returned the FRAUD NOTIFICATION form to DHHS.

SCDHHS Fraud Notification Key:

Section B

County:

SCDHHS Fraud Notification Key (cont.):

Provider Type:

Select a Value
00 Nursing Home
01 Inpatient Hospital
02 Outpatient Hopsital
10 Mental Health and Rehab
16 EPSDT
19 Other Medical Professional
20 Physician
22 Medical Clinics (includes RHC/FQHC)
30 Dentist
32 Optician
33 Optometrist
35 Podiatrist
37 Chiropractor
60 Home Health/Hospice
61 CLTC
70 Pharmacy
76 DME
80 Lab
81 X-Ray
82 Psychologist
99 Other:
04 Audiologist
06 Midwife
25 Nurse Anesthetist
84 Speech Therapist
85 Physical Therapist
86 Nurse Practitioner
87 Occupational Therapist
PC Licensed Professional Counselor
SW Licensed Independent Social Worker

Section C
Basis for Referral:

Select a Value
A: No documentation for service
B: Manufactured or altered documentation or forged signatures
C: Unapproved marketing/Recruitment of Patients
D: Use of another provider's ID by Excluded/Terminated individual
E: Billing for services, supplies or equipment that are not rendered or used for Medicaid members
F: Excessive cost or number of claims
G: Material misrepresentation of information on the claim
H: Billing unreasonable or improbable # units or services (Time Bandit)
I: Billing unreasonable or excessive amount of supplies or supplies clearly unsuitable to patients needs
J: Procedure codes/services do not correspond with provider type
K: Procedure code/ services/ #units not supported by member's diagnosis
L: Repeated patterns of up-coding and/or unbundling that result in large overpayment to provider
M: Unexplainable, significant spikes in claims volumes and reimbursement
N: Billing for numerous diagnostics with no documentation for medical necessity
O: Terminated for Cause
P: Confirmed BEOMB Complaint that Services were not delivered
Q: Other:

FRAUD Notification Form from SC DHHS PI

To: MCO Compliance Officer
From: SCDHHS, PI, Betsy Corley

MCO RETURN TO:

Upload completed FORM to the PI Share Point site, under MCO folder, Shared Documents

NOTIFICATION TYPE			
☐ Fraud Suspected Fraud, Referral to MFCU warranted			
*COORDINATION REQUIRED RESPOND BY			
Section A NOTIFICATION INFORMATION			
Date of Referral	Select Value		
MCO's Identified:	☒ Absolute (ATC) HM2200	☒ Blue Choice HM 3200	☒ Select Health HM1000
	☒ Advicare HM3400	☒ Molina HM3600	☒ Well Care HM3800
Person Reporting:			
Tel #:			
Investigator/Reviewer:			
Tel #:			
E-Mail:			
Section B PROVIDER INFORMATION			
Provider/Facility Name:			
Provider's Medicaid ID #:			
Address:			
City:	State:	Zip:	County: Select Value
Provider NPI(s):			
Provider SSN/EIN(s):	SSN: XXX-XX- / EIN:		
Provider Type:	Select a Value		
☐ Group or ☐ Individual			
Section C CASE/REVIEW INFORMATION			
Basis for Referral:	Select a Value		
Dates of Service Reviewed/Period in Question: START DATE	Select Value		
END DATE	Select Value		
Summary of Investigative Results:			

MCOs RESPONSE TO THE PI FRAUD NOTIFICATION:

DATE: ___/___/____

FRAUD Notification Form from SC DHHS PI

To: MCO Compliance Officer
From: SCDHHS, PI, Betsy Corley

MCO RETURN TO:

Upload completed FORM to the PI Share Point site, under MCO folder, Shared Documents

NOTIFICATION TYPE							
☐ Fraud Suspected Fraud, Referral to MFCU warranted							
*COORDINATION REQUIRED RESPOND BY							
Section A NOTIFICATION INFORMATION							
Date of Referral	Select Value						
MCO's Identified:	☒Absolute (ATC) HM2200	☒ Blue Choice HM 3200	☒ Select Health HM1000				
	☒ Advicare HM3400	☒ Molina HM3600	☒ Well Care HM3800				
Person Reporting:							
Tel #:							
Investigator/Reviewer:							
Tel #:							
E-Mail:							
Section B PROVIDER INFORMATION							
Provider/Facility Name:							
Provider's Medicaid ID #:							
Address:							
City:		State:		Zip:		County:	Select Value
Provider NPI(s):							
Provider SSN/EIN(s):	SSN: XXX-XX- / EIN:						
Provider Type:	Select a Value						
☐ Group or ☐ Individual							
Section C CASE/REVIEW INFORMATION							
Basis for Referral:	Select a Value						
Dates of Service Reviewed/Period in Question: START DATE	Select Value						
END DATE	Select Value						
Summary of Investigative Results:							

MCOs RESPONSE TO THE PI FRAUD NOTIFICATION:

DATE: __/__/____

Complaint/Case Notification Form from SC DHHS PI

To: MCO PI Compliance Officer
From: SCDHHS, PI, Betsy Corley
Via: E-Mail

Form to be delivered to the MCO PI Compliance Officer
From the MCO PI Coordinator (or PI Supervisor)
This form will be used by DHHS to notify the MCOs of potential Provider reviews.

NOTIFICATION TYPE		
☐ **Active Review** MCO claims identified during an Active FFS Review Indicates DHHS PI has an active review for the Provider/Member being referred	☐ **Completed Review** PI has completed review and identified an overpayment No MCO claims identified Indicates • DHHS PI has completed a review with an identified overpayment No MCO claims were identified during DHHS PI review	☒ **TIP** Complete Sections A, B and D. Used by DHHS to notify the MCO that regarding possible issues with a provider.

☐ **Active Review** MCO claims identified during an Active FFS Review	☐ **Completed Review** PI has completed review and identified an overpayment No MCO claims identified

Section A NOTIFICATION INFORMATION			
Date of Referral	Select Value		
	Date DHHS PI is making this referral to MCO(s)		
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.		
MCO's Identified:	☐Absolute (ATC) HM2200	☐ Blue Choice HM 3200	☐ Select Health HM1000
	☐Advicare HM3400	☐ Molina HM3600	☐ Well Care HM3800
	Check indicates all MCOs who will receive this referral. Check could indicate specific MCO(s), or it could serve as multi-notification.		
Person Reporting:	Name of DHHS PI individual making the referral		
Tel #:	Tele# of above listed DHHS PI individual making the referral		
Investigator/Reviewer:	Name of DHHS PI Investigator/Reviewer working the case		
Tel #:	Tele# of above listed DHHS PI Investigator/Reviewer working the case		
E-Mail:	E-Mail of above listed DHHS PI Investigator/Reviewer working the case		

Section B PROVIDER INFORMATION							
Provider/Facility Name:	Name of Provider or Facility being referred by DHHS PI						
Provider's Medicaid ID #:	Provider's DHHS ID as assigned by DHHS						
Address:	Provider's Street address (location under review)						
City:	City for above address	**State:**	State for above address	**Zip:**	Zip for above address	**County:**	Select Value
	COUNTY: Drop-Down Box. Select the County for the Provider Address listed above.						
Provider NPI(s):	Provider's NPI number(s)						

Complaint/Case Notification Form from SC DHHS PI

Provider SSN/EIN(s):	Provider's SSN or EIN used for billing claims
Provider Type:	Select a Value
	Drop-Down Box. Select the Provider Type for Provider being referred. If not listed, select OTHER and write it in.
☐ **Group** or ☐ **Individual**	Is Provider being referred a Group or Individual practice
Section C	**CASE/REVIEW INFORMATION**
Basis for Referral:	Select a Value
	Drop-Down Box. Select Referral Reason. If not listed, select OTHER and write it in.
Dates of Service Reviewed/Period in Question: START DATE	Select Value
DOS for which a review was conducted. Or time frame given in allegation	First date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.
END DATE	Select Value
	Last date of review or allegation.
	Use the Date Picker to select the date. Or highlight "Select Value" and type in the date using format MM/DD/YYYY.

Summary of Investigative Results:

This should be a synopsis of the investigation conducted by the DHHS PI reviewer, to include:

- Data reviewed – what stands out, ex specific Procedure Codes
- Interviews with the Provider and/or Members
- On-site visit
- Overpayments Determined / Letters Sent
- Current Status of the case

Section D TIP INFORMATION
Summary: : Provide all pertinent information as to why this provider is being referred. For example, loss of license, excluded in another state, etc... A TIP does not mean that DHHS has an active Complaint or Case against the provider.

SCDHHS Complaint Case Notification (Key):

Section B

County:

SCDHHS Complaint Case Notification (Key Cont.):

Provider Type:

- Select a Value
- 00 Nursing Home
- 01 Inpatient Hospital
- 02 Outpatient Hopsital
- 10 Mental Health and Rehab
- 16 EPSDT
- 19 Other Medical Professional
- 20 Physician
- 22 Medical Clinics (includes RHC/FQHC)
- 30 Dentist
- 32 Optician
- 33 Optometrist
- 35 Podiatrist
- 37 Chiropractor
- 60 Home Health/Hospice
- 61 CLTC
- 70 Pharmacy
- 76 DME
- 80 Lab
- 81 X-Ray
- 82 Psychologist
- 99 Other:
- 04 Audiologist
- 06 Midwife
- 25 Nurse Anesthetist
- 84 Speech Therapist
- 85 Physical Therapist
- 86 Nurse Practitioner
- 87 Occupational Therapist
- PC Licensed Professional Counselor
- SW Licensed Independent Social Worker

Section C

Basis for Referral:

- Select a Value
- A: No documentation for service
- B: Manufactured or altered documentation or forged signatures
- C: Unapproved marketing/Recruitment of Patients
- D: Use of another provider's ID by Excluded/Terminated individual
- E: Billing for services, supplies or equipment that are not rendered or used for Medicaid members
- F: Excessive cost or number of claims
- G: Material misrepresentation of information on the claim
- H: Billing unreasonable or improbable # units or services (Time Bandit)
- I: Billing unreasonable or excessive amount of supplies or supplies clearly unsuitable to patients needs
- J: Procedure codes/services do not correspond with provider type
- K: Procedure code/ services/ #units not supported by member's diagnosis
- L: Repeated patterns of up-coding and/or unbundling that result in large overpayment to provider
- M: Unexplainable, significant spikes in claims volumes and reimbursement
- N: Billing for numerous diagnostics with no documentation for medical necessity
- O: Terminated for Cause
- P: Confirmed BEOMB Complaint that Services were not delivered
- Q: Other:

Complaint/Case Notification Form from SC DHHS PI

To: MCO Compliance Officer
From: SCDHHS, PI, Betsy Corley

NOTIFICATION TYPE		
☐ **Active Review** MCO claims identified during an Active FFS Review	☐ **Completed Review** PI has completed review and identified an overpayment No MCO claims identified	☐ **TIP** Complete Sections A, B and D.

Section A NOTIFICATION INFORMATION			
Date of Referral	Select Value		
MCO's Identified:	☐Absolute (ATC) HM2200	☐ Blue Choice HM 3200	☐ Select Health HM1000
	☐Advicare HM3400	☐ Molina HM3600	☐ Well Care HM3800
Person Reporting:			
Tel #:			
Investigator/Reviewer:			
Tel #:			
E-Mail:			

Section B PROVIDER INFORMATION						
Provider/Facility Name:						
Provider's Medicaid ID #:						
Address:						
City:		**State:**		**Zip:**	**County:**	Select Value
Provider NPI(s):						
Provider SSN/EIN(s):						
Provider Type:	Select a Value					
☐ **Group** or ☐ **Individual**						

Basis for Referral:	Select a Value	
Dates of Service Reviewed/Period in Question:	**START DATE**	Select Value
	END DATE	Select Value

Summary of Investigative Results:

Section D TIP INFORMATION
Summary:

To: MCO Compliance Officer
From: SCDHHS, PI, Betsy Corley

NOTIFICATION TYPE			
BEOMB NOTIFICATION Beneficiary Explanation of Medicaid Benefits			
Section A NOTIFICATION INFORMATION			
Date of Referral	Select Value		
MCO Identified:	☐ Absolute (ATC) HM2200	☐ Blue Choice HM 3200	☐ Select Health HM1000
	☐ Advicare HM3400	☐ Molina HM3600	☐ Well Care HM3800
Person Reporting:			
Tel #:			
Investigator/Reviewer:			
Tel #:			
E-Mail:			
Section B PROVIDER INFORMATION			
Provider/Facility Name:			
Section B MEMBER INFORMATION			
Member Name:			
Section C CASE/REVIEW INFORMATION			
Summary of Investigative Results: Member has indicated on the BEOMB that they did not receive the indicated service(s). Per the PP for MCOs, Section 15.5, please "conduct a preliminary investigation to determine whether the services were provided as reported in the encounter. If the MCO finds any indication of fraud or abuse, it will forward the BEOMB issue to PI, using the Fraud and Abuse Referral Form".			
Section D ATTACHED DOCUMENTS			
☐ BEOMB ☐ Detailed Claims Report (DCR) ☐ MMIS Provider/Member Screen Shot ☐ Other			

MCO PAYMENT SUSPENSION LETTER:

CERTIFIED MAIL

Personal and Confidential

Dear <Provider> :
The purpose of this letter is to inform you that in conjunction with the letter issued to you on <date of SCDHHS letter> by the South Carolina Department of Health and Human Services (SCDHHS), <Plan Name> will be withholding payment for services issued under <Group/Individual ID> for <Group/Individual Name>. The action taken by SCDHHS is in accordance with 42 CFR § 455.23 regarding suspension of payments in cases of a credible allegation of fraud.
SCDHHS requires that in response to the suspension of payments in cases of credible allegations of fraud that <Plan Name> also suspend payments. The withholding of payments will continue until <Plan Name> is notified by SCDHHS that SCDHHS or the Medicaid Fraud Control Unit of the State Attorney General's Office has determined that there is insufficient evidence of fraud by the provider or that legal proceedings related to the alleged fraud are completed.
The State authority for this review and recovery of improper payments can be found at South Carolina Code of Regulations 126.400 *et seq*., ; the federal authority may be found at 42 CFR § 433.300 *et seq*.; see also 42 CFR § 431.107; 42 CFR Part 455; and 42 CFR Part 456.
Please do not hesitate to call should you have any questions regarding this letter.
Sincerely,

<Plan Representative Name>
<Plan Name>

Enclosure: Healthy Connections Medicaid Payment Suspension Letter dated <xxxxx>
cc: Betsy Corley, SCDHHS PI

Program Integrity Instructions for use of SharePoint for Reporting Provider Suspensions, Terminations and Exclusions:

INITIAL PI SHARE POINT PAGE
Potential Matches
This folder will contain "Potential Matches" that DHHS PI has identified thru our searchs against National and Federal Databases for Terminations and Exclusions.
It is the Plan's responsibility to review these matches against their active provider list.
If the Plan has a positive match with an active provider, the Plan must take the appropriate action (ie terminating the provider).
The Plan must notify DHHS PI of its action on the Provider Referral Form using the Terminated Provider Section.
DHHS Suspensions
These are providers who have been Suspended by DHHS PI; in most all cases for a credible allegation of fraud.
These provider's payments have been converted into a hard copy check and are being withheld by DHHS.
The provider is still able to submit claims and have them processed.... They are just not to receive payment for the claims until the pending issue is resolved.
Once Suspended by DHHS, the Plan must follow DHHS's suspension. The Plan must also suspend the provider's payment.
The Plan must record their Suspension action on this spreadsheet. (See the attached example with Data Dictionary)
If the DHHS PI suspended provider IS NOT a Plan provider, that will be indicated on this spreadsheet.
If the DHHS PI suspended provider IS a Plan provider, the Plan must Suspend the provider with a Suspension Letter (with the PI approved template) and indicate the letter date on this spreadsheet.
The Suspension Letter must be uploaded to the "Suspension Letter" folder on the Plan's individual Share Point folder on the PI site.
If the DHHS PI Suspension is lifted, the Plan will be notified and they must also lift the Suspension and indicate the date on this spreadsheet.
This list should always be consulted when enrolling a new provider.
DHHS Exclusions
These are providers Excluded by DHHS PI; in most cases as a result of a MFCU investigation or following a Federal OIG action.
These provider's payments have been stopped, they cannot continue to submit claims for processing and they are rendered inactive by DHHS.
Once Excluded by DHHS, the Plan must acknowledge DHHS's Exclusion with a Termination from the Plan.
The Plan must also have the means to stop payments for claims in which the Excluded provider prescribed, ordered or referred.
The Plan must record their Termination action on this spreadsheet. (See the atttached example with a Data Dictionary)
The Termination Letter must be uploaded to the "Termination Letter" folder on the Plan's individual Share Point folder on the PI site.
If the DHHS PI Exclusion is lifted, the Plan will be notified and they must also lift the Termination and indicate the date on this spreadsheet.
This list should always be consulted when enrolling a new provider.
DHHS Terminations
These are providers Terminated by DHHS PI; in most cases as a result Plan actions or other State Agency actions.
These provider's payments have been stopped, they cannot continue to submit claims for processing and they are rendered inactive by DHHS.
Once Terminated by DHHS, the Plan must follow DHHS's termination. THe Plan must also terminate the provider.
The Plan must record their Termination action on this spreadsheet. (See the atttached example with a Data Dictionary)
The Termination Letter must be uploaded to the "Termination Letter" folder on the Plan's individual Share Point folder on the PI site.
If the DHHS PI Termination is lifted, the Plan will be notified and they must also lift the Termination and indicate the date on this spreadsheet.
This list should always be consulted when enrolling a new provider.
***NOTE**
The Plan will continue to send PI their Monthly Termination Report and Terminated Provider Referral Forms.
By way of these Reports and Forms, the Plan will be notifying DHHS of their Plan Terminated Providers.
If we research an individual Plan's Terminated Provider and he meets all criteria, that provider will be published for all Plans to terminate.
PI will notify the Complinace Officer for any Suspensions, Exclusions or Termiantions against providers.
DHHS Prov Letters
This folder will house all PI letters of Suspension, Exclusion and Termination to the providers.
INDIVIDUAL PLAN'S FOLDER ON PI SHARE POINT PAGE
Shared Documents
This folder will house any and all documens the Plan must share with PI; such as large files in connection to a referral, as part of an investigation or general correspondence.
If the Plan uploads a document to this folder, they MUST NOTIFY the receiving party within PI that the document has been uploaded.
Suspension Letters
When following a DHHS Provider Suspension, the Plan must notify the provider (using the DHHS Suspension Letter Template) that his payments are being Suspended by the Plan.
The Plan must upload a copy of that letter in this folder as documentation that they took the same action against the provider as did PI.
In addition, the Plan must update the spreadsheet in the DHHS Suspension folder documenting their actions.
Termination Letters (to include Terminations and Exclusions)
When following a DHHS Provider Termination/Exclusion, the Plan must notify the provider that he is being Terminated by the Plan.
The Plan must upload a copy of that letter in this folder as documentation that they took the same action against the provider as did PI.
In addition, the Plan must update the spreadsheet in the DHHS Termination/Exclusion folder(s) documenting their actions.
Termination Reports (NO CHANGES)
This folder will remain the same. The Plan will upload their Termination report notifying DHHS PI of termination actions they have taken against their providers.

Provider Suspensions

DHHS Suspensions
These are providers who have been Suspended by DHHS PI; in most all cases for a credible allegation of fraud.
These provider's payments have been converted into a hard copy check and are being withheld by DHHS.
The provider is still able to submit claims and have them processed.... They are just not to receive payment for the claims until the pending issue is resolved.
Once Suspended by DHHS, the Plan must follow DHHS's suspension. The Plan must also suspend the provider's payment.
The Plan must record their Suspension action on this spreadsheet. (See the attached example with Data Dictionary)
If the DHHS PI suspended provider IS NOT a Plan provider, that will be indicated on this spreadsheet.
If the DHHS PI suspended provider IS a Plan provider, the Plan must Suspend the provider with a Suspension Letter (with the PI approved template) and indicate the letter date on this spreadsheet.
The Suspension Letter must be uploaded to the "Suspension Letter" folder on the Plan's individual Share Point folder on the PI site.
If the DHHS PI Suspension is lifted, the Plan will be notified and they must also lift the Suspension and indicate the date on this spreadsheet.
This list should always be consulted when enrolling a new provider.

Provider Suspension Template Found on Program Integrity SharePoint Site

Status: A/R/D	Provider Name	NPI Number	SCDHHS Prov #	Indiv/Entity	MMIS PE Stat	Dt Added	MMIS Suspended Dt	MMIS Removed Dt	SCDHHS Reason Removed	ATC Y/N	ATC Dt Suspended	ATC Dt Removed	ATC Reason Removed	Advicare Y/N	Advicare Dt Suspended	Advicare Dt Removed	Advicare Reason Removed	BlueChoice Y/N	BlueChoice Dt Suspended	BlueChoice Dt Removed	BlueChoice Reason Removed	Molina Y/N	Molina Dt Suspended	Molina Dt Removed	Molina Reason Removed	Select Y/N	Select Dt Suspended	Select Dt Removed	Select Reason Removed	WellCare Y/N	WellCare Dt Suspended	WellCare Dt Removed	WellCare Reason Removed
A	Provider A	1234567890	GP123	I	3	2/6/2014	2/6/2014																										
R	Provider B	2345678901	PC345	E	1	6/25/2015	6/25/2015	10/1/2015	Case Completed by MFCU																								
D	Provider C	3456789012	T5678	I	1	12/1/2015	12/1/2014	12/20/2014	Incorrect Provider																								
Status: A/R/D	Provider Name	NPI Number	SCDHHS Prov #	Indiv/Entity	MMIS PE Stat	Dt Added	MMIS Suspended Dt	MMIS Removed Dt	SCDHHS Reason Removed	ATC Y/N	ATC Dt Suspended	ATC Dt Removed	ATC Reason Removed	Advicare Y/N	Advicare Dt Suspended	Advicare Dt Removed	Advicare Reason Removed	BlueChoice Y/N	BlueChoice Dt Suspended	BlueChoice Dt Removed	BlueChoice Reason Removed	Molina Y/N	Molina Dt Suspended	Molina Dt Removed	Molina Reason Removed	Select Y/N	Select Dt Suspended	Select Dt Removed	Select Reason Removed	WellCare Y/N	WellCare Dt Suspended	WellCare Dt Removed	WellCare Reason Removed
A = Active	Provider's Name	Providers NPI number	DHHS Provider ID	I = Individual provider	Provider Enrollment Status in MMIS	Date Suspension added to Check Pull List	Date Suspension added in MMIS	Date Suspension removed in MMIS	Reason DHHS removed provider from suspension list	**FOR EACH PLAN**	.....	.....	.....	.....	.....	.....	.....																
R = Removed				E = Entity						Y = Provider is in your Plan	Date Plan Suspended provider	Date Plan reinstated provider																					
D = Deleted										N = Provider is not in your Plan; therefore, you cannot suspend																							
When SCDHHS/PI Suspends a Provider's payments, they will be added to this list and the Plan will be notified. The Plan will need to update their 3 columns to reflect the actions they have taken.																																	
If a Plan indicates they have Suspended the provider's payments, they will need to place a copy of the Suspend Letter in the "Suspension Letter" folder on their individual site.																																	

Provider Exclusions:

DHHS Exclusions
These are providers Excluded by DHHS PI; in most cases as a result of a MFCU investigation or following a Federal OIG action.
These provider's payments have been stopped, they cannot continue to submit claims for processing and they are rendered inactive by DHHS.
Once Excluded by DHHS, the Plan must acknowledge DHHS's Exclusion with a Termination from the Plan.
The Plan must also have the means to stop payments for claims in which the Excluded provider prescribed, ordered or referred.
The Plan must record their Termination action on this spreadsheet. (See the atttached example with a Data Dictionary)
The Termination Letter must be uploaded to the "Termination Letter" folder on the Plan's individual Share Point folder on the PI site.
If the DHHS PI Exclusion is lifted, the Plan will be notified and they must also lift the Termination and indicate the date on this spreadsheet.
This list should always be consulted when enrolling a new provider.

Provider Exclusions Template Found on Program Integrity SharePoint Site

Individual/Entity	NPI	City	State	Zip	Last Known Profession/Provider Type	Dt Excluded	ATC Y/N	ATC TFC Dt	ATC Rein Dt	Advicare Y/N	Advicare TFC Dt	Advicare Rein Dt	BlueChoice Y/N	BlueChoice TFC Dt	BlueChoice Rein Dt	Molina Y/N	Molina TFC Dt	Molina Rein Dt	Select Health Y/N	Select Health TFC Dt	Select Health Rein Dt	Wellcare Y/N	Wellcare TFC Dt	Wellcare Rein Dt
Provider A	not found	Anderson	SC	29625	Health Care Aide	7/19/2012																		
Provider B	1234567890	Columbia	SC	29223	Optician	8/18/2009																		
Provider C	2345678901	Orangeburg	SC	29116	Chiropractor	4/20/2014																		
Individual/Entity	NPI	City	State	Zip	Last Known Profession/Provider Type	Dt Excluded	ATC Y/N	ATC TFC Dt	ATC Rein Dt	Advicare Y/N	Advicare TFC Dt	Advicare Rein Dt	BlueChoice Y/N	BlueChoice TFC Dt	BlueChoice Rein Dt	Molina Y/N	Molina TFC Dt	Molina Rein Dt	Select Health Y/N	Select Health TFC Dt	Select Health Rein Dt	Wellcare Y/N	Wellcare TFC Dt	Wellcare Rein Dt
Provider or Entity's Name	Providers NPI Number	Provider's City	Provider's State	Provider's Zip	Provider's last know profession or the provider type	Date DHHS excluded provider	**FOR EACH PLAN**	.....	.....	.....	.....	.....	.....	.....										
							Y = Provider is in your Plan	Date Plan Terminated provider	Date Plan reinstated provider															
							N = Provider is not in your Plan; therefore, you cannot terminate																	
When a Provider is Excluded, SCDHHS/PI will add them to this list. When providers are added, the Plan will need to update their 3 columns to reflect the actions they have taken.																								
Because Plans cannot Exclude a provider, they must follow DHHS's Exclusion with a Termination.																								
If a Plan indicates they have Terminated a provider's payments, they will need to place a copy of the Termination Letter in the "Termination Letter" folder on their individual site.																								
They will need to make assurances the provider's payments have been terminated for the period indicated.																								
The provider cannot continue to bill services during this time.																								

Provider Terminations:

DHHS Terminations
These are providers Terminated by DHHS PI; in most cases as a result Plan actions or other State Agency actions.
These provider's payments have been stopped, they cannot continue to submit claims for processing and they are rendered inactive by DHHS.
Once Terminated by DHHS, the Plan must follow DHHS's termination. THe Plan must also terminate the provider.
The Plan must record their Termination action on this spreadsheet. (See the atttached example with a Data Dictionary)
The Termination Letter must be uploaded to the "Termination Letter" folder on the Plan's individual Share Point folder on the PI site.
If the DHHS PI Termination is lifted, the Plan will be notified and they must also lift the Termination and indicate the date on this spreadsheet.
This list should always be consulted when enrolling a new provider.

Provider Terminations Template Found on Program Integrity SharePoint Site

NPI	A/R	Provider Name	Legacy	I/E	SSN	EIN	Cause	MMIS Updated	Effective Dt	Reinstated Dt	Reinstatement Reason	ATC Y/N	ATC TFC Dt	ATC Rein Dt	Advicare Y/N	Advicare TFC Dt	Advicare Rein Dt	BlueChoice Y/N	BlueChoice TFC Dt	BlueChoice Rein Dt	Molina Y/N	Molina TFC Dt	Molina Rein Dt	Select Health Y/N	Select Health TFC Dt	Select Health Rein Dt	Wellcare Y/N	Wellcare TFC Dt	Wellcare Rein Dt
1234567890	A	Provider A	012345	I	123-45-6789	123456789	Adverse Licensure	5/29/2013	12/19/2013																				
2345678901	R	Provider B	234567	I	234-56-7890		Adverse Licensure	7/15/2014	1/17/2015	7/25/2015	Renewed license																		
3456789801	A	Provider C	GP1234	E		234567890	Denied Records Access to OAG	9/20/2015	9/14/2015																				
NPI	A/R	Provider Name	Legacy	I/E	SSN	EIN	Cause	MMIS Updated	Effective Dt	Reinstated Dt	Reinstatement Reason	ATC Y/N	ATC TFC Dt	ATC Rein Dt	Advicare Y/N	Advicare TFC Dt	Advicare Rein Dt	BlueChoice Y/N	BlueChoice TFC Dt	BlueChoice Rein Dt	Molina Y/N	Molina TFC Dt	Molina Rein Dt	Select Health Y/N	Select Health TFC Dt	Select Health Rein Dt	Wellcare Y/N	Wellcare TFC Dt	Wellcare Rein Dt
Providers NPI number	A = Active Termination	Provider Name	DHHS Legacy ID	I = Individual Provider	Providers SSN of Individual	Providers EIN if Entity	Reason Terminated	Date MMIS was updated with the Termination	Effective date of the Termination by DHHS	Date provider is reinstated by DHHS	Reason provider is reinstated	**FOR EACH PLAN**	.....	.....	.....	.....	.....	.....	.....										
	R = Removed Termination			E = Entity Provider	(Possible both SSN and EIN)							Y = Provider is in your Plan	Date Plan Terminated provider	Date Plan reinstated provider															
												N = Provider is not in your Plan, therefore, you cannot terminate																		
When a Provider is Terminated, SCDHHS/PI will add them to this list. When providers are added, the Plan will need to update their 3 columns to reflect the actions they have taken.																													
If a Plan indicates they have Terminated a provider's payments, they will need to place a copy of the Termination Letter in the "Termination Letter" folder on their individual site.																													
They will need to make assurances the providers payments have been terminated for the period indicated.																													
The provider cannot continue to bill services during this time.																													

Section 16.3.1 Managed Care Question and Answer Grid

Frequency: As Needed

On occasion the MCO's may need to ask questions of SCDHHS. SCDHHS has developed the following form to allow plans the ability to ask questions of SCDHHS.

1. Number: Number of the question.
2. Question: The MCO's question of SCDHHS.
3. Contract or Policy Section Page: The section of either the P&P or the contract that caused the original question to SCDHHS.
4. Submitted by: The person submitting the question.
5. Date Submitted: The date that the question was submitted.
6. SCDHHS Answer: The answer submitted by SCDHHS.
7. Answered by: The individual at SCDHHS submitting the final answer to the MCO.
8. Date Answered: The date that the individual at SCDHHS answered the question.

Question and Answer Grid Format

Question and Answer Grid							
Plan Name							
	Health Plan				DHHS		
NUMBER	QUESTION	Contract or Policy and Procedure Guide Section/Page	SUBMITTED BY (Name)	DATE SUBMITTED	SCDHHS ANSWER	ANSWERED BY	DATE ANSWERED

REPORT REQUIREMENTS

MONTHLY

Managed Care Report Name	Format	Report Timing
Monthly Reporting Requirements		
Section 3		
Section 3.2		
Eligibility Redetermination	Report produced for MCO's when someone is getting Medicaid eligibility redeterminations completed by SCDHHS.	Monthly
Section 3.8		
Manual Maternity Kicker	Maternity Kicker Form for use when automated process does not function correctly	Monthly
Section 3.19.17		
Call Center Performance	Call center performance metrics for Member English language line, Member Spanish language line, and Provider call center.	Monthly
Section 5		
Section 5.4.5.1		
Care Management	Report of all members receiving care management services on an ongoing basis with the MCO.	Monthly
Section 6		
Section 6.3.1 through 6.3.3.3		
Provider Network	MCO report sent to both the enrollment broker and the agency indicating the MCO's current network providers.	Monthly prior to the third Thursday in month
Section 7		
Section 7.3.1.1		
Dual Medicare Medicaid	Report produced for the MCO's to account for retro-active dual eligible Medicare recoupments for up to a year in arrears.	Monthly
PCMH	Patient Centered Medical Homes. MCO's submission is monthly, SCDHHS pays the MCO's on a quarterly basis. Utilized to reimburse those primary care practices that qualify for this incentive payment.	Monthly
Manual Maternity Kicker	See section 3.8 above.	Monthly
Section 10		
Section 10.9.1 through 10.9.1.4		
TPL Verification	Third Party Liability (TPL) Verification Report indicates those members the MCO indicates have third party insurance coverage. This report is submitted via the departments FTP site.	Monthly
TPL Cost Avoidance	TPL cost avoidance report indicates those claims that the MCO has cost avoided during the month.	Monthly
TPL COB Savings	TPL Coordination of Benefits (COB) report indicates those claims leading to coordination of benefits savings for the MCO.	Monthly
TPL Recoveries	Recoveries that the MCO have made as a result of research for members with potential or known third party coverage.	Monthly
TPL Casualty Cases	Any casualty cases that the MCO is aware are ongoing.	Monthly
Section 11		
Section 11.6		
Monthly MCO Fraud and Abuse	Monthly reporting of fraud and abuse. This report should be submitted directly to Program Integrity's SharePoint site.	Monthly
Termination Denial for Cause	Reporting of terminated providers. This report should be submitted directly to Program Integrity's SharePoint site.	Monthly
Section 13		
Table 13.1		
Claims Payment Accuracy	Report detailing monthly claim payment by the MCO.	Monthly
Section 14		
Section 14.5		
Encounter Submission Summary	Report detailing totals for monthly claims paid, accepted encounters, rejected encounters, and completeness percentage.	Monthly

(Company Letter Head)
Attestation for Reports

Date_____

I, _____, as (Title) for (Name of Company), do hereby attest, based upon my best knowledge, information and belief, that the data provided in the encounters and Patient Centered Medical Home Report are accurate, true, and complete.
I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to liquidated damages, sanctions and/or fines as outlined in Section 18 of the contract.

_____ _____
Signature/Title Date

Section 3.2: Redetermination Report: There are two redetermination reports. These reports are produced for the MCO's to indicate whom is getting Medicaid redeterminations in the month. The file names are:

MEDS File: &<hlq>.vendor-ID.REVIEW.FILE and &<hlq>.vendor-ID.REVIEW.FILE.MCF
CURAMFile: &<hlq>.vendor-ID.REVIEW**C**.FILE and &<hlq>.vendor-ID.REVIEW**C**.FILE.MCF

Files are created after cutoff each month which is normally the third Thursday of the month which falls between the 20th and 26th of the month.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	REV-FAMILY –NUMBER	8	1	8	C	Recipient identifying family number.
2.	Filler	1	9	9		
3.	REV-RECIP-NO	10	10	19	C	Recipient identifying Medicaid number.
4.	Filler	1	20	20		
5.	REV-RECIP-NAME	20	21	40	C	Recipient name, Last,First, Middle Initial
6.	Filler	1	41	41		
7.	REV-ADDR-STREET	25	42	66	C	
8.	Filler	1	67	67		
9.	REV-ADDR-CITY	20	68	87	C	
10.	Filler	1	88	88		
11.	REV-ADDR-STATE	2	89	90	C	
12.	Filler	1	91	91		
13.	REV-ADDR-ZIP	5	92	96	C	
14.	Filler	1	97	97		
15.	REV-ADDR-PHONE	15	98	112	C	
16.	Filler	1	113	113		
17.	REV-REVIEW-DATE	10	114	123	N	CCYY-MM-DD
18.	Filler	1	124	124		
19.	REV-REVIEW-MAILED	10	125	134	N	CCYY-MM-DD
20.	Filler	1	135	135		
21.	REV-PROVIDER-NO	6	136	141	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
22.	Filler	1	142	142		
23.	REV-BOARD-PROV-NO	6	143	148	C	Applicable for medical home programs only
24.	Filler	1	149	149		
25.	REV-PAYEE-NAME	25	150	174	C	Name of payee for family
26.	Filler	1	175	175		
27.	REV-PAYEE-TYPE	3	176	178	C	Payee Type: See Note 1 below.
28.	Filler	1	179	179		
29.	REV-RECIP-PAY-CAT	2	180	181	C	Pay Categories: See Note 2 below.
30.	Filler	1	182	182		
31.	COUNTY-WORKER-FIRST-NAME	17	183	199	C	
32.	Filler	1	200	200		
33.	COUNTY-WORKER-LAST-NAME	26	201	226	C	
34.	Filler	1	227	227		
35.	COUNTY-WORKER-PHONE	10	228	237	C	
36.	Filler	1	238	238		
37.	COUNTY-WORKER-PHONE-EXTENSION	4	239	242	C	
38.	Filler	1	243	243	C	
39.	HOUSEHOLD NUMBER	9	244	252	C	Ties households together.
40.	Filler	48	253	300		

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left EX: 5 bytes 123 will appear as 00123
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

Logic for inclusion in this file is as follows:

```
WHERE  BG.BG_CDE_STATUS = 'A'
       AND BG.BG_CDE_ACTION = 'R'
       AND ((BG.BG_DTE_FORM_MAILED <= CURRENT DATE - 30 DAYS)
       OR (BG.BG_DTE_FORM_MAILED IS NULL))
       AND BG.BG_DTE_FORM_RECD IS NULL
       AND BG.BG_NUM_PYMT_CATEGORY IN ('12','15','16','17','18',
         '19','32','40','57','59','71','88')
      AND BG.BG_UID_WORKER_ID = WKR.WKR_UID_WORKER_ID
      AND BG.BG_NUM_BUDGET_GROUP_ID = HB.HBJ_NUM_BUDGET_GROUP_ID
      AND BG.BG_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID
      AND MEH.MEH_NUM_MEMBER_ID = BMJ.BMJ_NUM_MEMBER_ID
      AND MEH.MEH_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID
      AND MEH.MEH_DTE_INELIG IS NULL
      AND WKR.WKR_CDE_COUNTY = LOC.LOC_CDE_COUNTY
      AND WKR.WKR_CDE_LOCATION = LOC.LOC_CDE_LOCATION
```

Note 1: Payee Types for Field 27.
SEL SELF OR AFDC PAYEE
GDN LEGAL GUARDIAN
REL OTHER RELATIVE
AGY SOCIAL AGENCY
PPP PROTECTIVE PAYEE
REP REPRESENTATIVE PAYEE
FOS INDICATES FOSTER CHILD
SPO SPOUSE
INP LEGALLY INCOMPETENT, NO REPRESENT

Note 1: Payment Categories for Field 29.
10 MAO (NURSING HOMES)
11 MAO (EXTENDED TRANSITIONAL)
12 OCWI (INFANTS UP TO AGE 1)

13 MAO (FOSTER CARE/SUBSIDIZED ADOPTION)
14 MAO (GENERAL HOSPITAL)
15 MAO (CLTC)
16 PASS-ALONG ELIGIBLES
17 EARLY WIDOWS/WIDOWERS
18 DISABLED WIDOWS/WIDOWERS
19 DISABLED ADULT CHILD
20 PASS ALONG CHILDREN
30 AFDC (FAMILY INDEPENDENCE)
31 TITLE IV-E FOSTER CARE
32 AGED, BLIND, DISABLED
33 ABD NURSING HOME
40 WORKING DISABLED
41 MEDICAID REINSTATEMENT
48 S2 SLMB
49 S3 SLMB
50 QUALIFIED WORKING DISABLED (QWDI)
51 TITLE IV-E ADOPTION ASSISTANCE
52 SLMB (SPF LOW INC MEDCARE BENEFICIAR)
53 NOT CURRENTLY BEING USED
54 SSI NURSING HOMES
55 FAMILY PLANNING
56 COSY/ISCEDC
57 KATIE BECKETT CHILDREN - TEFRA
58 FI-MAO (TEMP ASSIST FOR NEEDY)
59 LOW INCOME FAMILIES
60 REGULAR FOSTER CARE
68 FI-MAO WORK SUPPLEMENTATION
70 REFUGEE ENTRANT
71 BREAST AND CERVICAL CANCER
80 SSI
81 SSI WITH ESSENTIAL SPOUSE
85 OPTIONAL SUPPLMENT
86 SUPPLEMENT & SSI
87 OCWI (PREGNANT)

88 OCWI (CHILD UP TO 19)
90 MEDICARE BENE(QMB)
91 RIBICOFF CHILDREN
92 ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE

Section 3.8: Manual Maternity Kicker

MCO maternity kicker payments for newborns enrolled in an MCO during the first three months of life will have the monthly automated maternity kicker payment calculated as part of the monthly automated/systemic capitation process.

For those cases where the MCO did not receive a maternity kicker payment through the automated/systemic process, and in cases where there is a stillborn birth, the MCO of the enrolled mother must submit the *Manual Maternity Kicker* reporting template found in the report companion guide and at the following location, in order to request payment.
https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

The MCO is expected to work with the eligibility team to obtain accurate and complete information on newborns when this information is not known to the MCO.

Requests for manual maternity kicker payments may only be made between the fourth and sixth month after birth. The table on the following page below indicates for each birth month, when the manual maternity kicker payments may be submitted. SCDHHS, at its discretion, may consider payments beyond this timeline.

Completed forms are to be uploaded to the Department's SharePoint site in the MCO's monthly libraries. Once uploaded to SharePoint the Department will review the submissions for appropriateness and submit a Gross Level Adjustment for any maternity kicker payments due to the MCO. A copy of the MCO's submitted Maternity Kicker Template will be returned to the MCO upon processing of the requests. Any payments made will be indicated on the form.

In order to be processed as a manual maternity kicker for newborns and stillborns, the form must be completed as follows:

1) In months 1-5:
    a. For newborns: All fields on the form must be completed for the mother AND the newborn. Entries that are incomplete will not be processed. The MCO will need to resubmit these entries in a subsequent acceptable period.
    b. For Stillborns: All fields on the form must be completed for the mother and the date of birth must be completed for the stillborn. Encounter records will be used to validate these deliveries.
2) In month 6:
    a. For newborns: At a minimum, all fields for the mother must be completed and the child's date of birth and sex must be completed.
        i. SCDHHS will review the accepted encounter transactions for the mother in month 6 when the newborn's name and Medicaid ID are not indicated on the maternity kicker payment notification log, searching for a diagnosis and/or a procedure code that indicates a delivery.
        ii. SCDHHS will process any maternity kicker reported in month 6 when SCDHHS reviewed encounter records confirm the delivery.

MANUAL MATERNITY KICKER REQUEST SCHEDULE			
BIRTH MONTH	**MK AUTO PAY MONTHS**	**MANUAL MK REQUEST MONTHS**	**MONTH REPORTS RECEIVED by SCDHHS**
January	January February March	April May June	May June July
February	February March April	May June July	June July August
March	March April May	June July August	July August September
April	April May June	July August September	August September October
May	May June July	August September October	September October November
June	June July August	September October November	October November December
July	July August September	October November December	November December January
August	August September October	November December January	December January February
September	September October November	December January February	January February March

October	October November December	January February March	February March April
November	November December January	February March April	March April May
December	December January February	March April May	April May June

Stillborn births do not require a waiting period to be reported since no Medicaid ID number is assigned to a stillborn. The baby must be alive at the time of birth to be Medicaid eligible. Indicate with an "X" for multiple births. Otherwise, do not fill in this column.

Count: Numerical count of lines reported - 1, 2, 3….

Newborns Date of Birth: date of birth of newborn format – 00/00/00

Mother's Last Name: Add the mothers last name

Mother's First Name: Add the mother first name

Mother's Medicaid ID Number: Mother's Medicaid ID number – 10 digits

Newborn's Last Name: Add the newborn's last name. If name is not known, use "Baby Boy" or "Baby Girl"

Newborn's First Name: Add the newborn's first name. Not applicable if name is not known

Newborn's Sex: Use M for male, F for female

Multiple Births: Please place an "X" in this column for any multiple birth situations. Regardless of how many births you will only be reimbursed for one maternity kicker.

* These columns reserved for SCDHHS use

Manual Maternity Kicker

Frequency – Monthly as necessary

MCO Name (MCO ID)											
Maternity Kicker Payment Notification Log											
Date (Unpaid Through Date)											
		Mother's Information			Newborn's Information					Reserved for SCDHHS use	
Count	Newborn's DOB (mm/dd/yy)	Last Name	First Name	Mother's Medicaid ID	Last Name	First Name	Child's Medicaid ID	NB Sex (M/F)	Multiple Birth? (X=Yes)	Y/N	$ amt
Stillborn Deliveries Below This Line											

Section 3.19.17: Call Center Performance: This report is to be submitted to the MCO's monthly SharePoint library. The report should have three worksheets (tabs) to report the call center metrics for the member English line, member Spanish line, and the provider call center.

Member Call Center – English Language Line

Monthly Managed Care Organization (MCO) Member Call Center Report (English Language Line)						
Report Date: (mm/dd/yyyy)						
Metric	**Definition of Metric**	**Current Year/ Current Month Totals**	**Previous Year/ Current Month Totals**	**Current Fiscal Year to Date Totals**	**Previous Fiscal Year to Date Totals**	**Performance Metrics**
Total Member Calls	The total number of Member Calls in the reporting Period.					
Total Blocked Calls	A blocked call is one that cannot be completed because of a busy condition. The total number of blocked calls in the reporting Period.					
Percentage (%) Blocked Calls	The total calls blocked divided by total member calls multiplied by 100.					
Calls handled by Interactive Voice Response (IVR) System	An interactive voice response (IVR) unit is a device that automates retrieval and processing of information by phone using touchtone signaling or voice recognition to access information residing on a server. The response may be given by a recorded human voice or a synthesized (computerized) voice. IVRs are used in applications such as "bank by phone" or "check on my order," which distribute information and collect transaction information. The total number of calls handled by the IVR system that did not require human intervention.					
Percentage (%) of Member Calls Passing Directly to the IVR	Total number of calls that went directly to the IVR system divided by total member calls multiplied by 100.					
Total Calls Requiring Callback/Messaging	The total number of calls during the Period that required callback as a result of the initial call being sent to a voice messaging system. This may occur for many reasons but examples include those calls diverted due to high call volume and no operator availability or after hours messages.					
Total Calls making it to Operator Queue	These are the total calls during the Period that made it into the Queue for human interaction. The calls that could not be assisted by the IVR or did not want to use the IVR system.					
Total Calls Answered in Queue	These are the total calls during the Period that were answered and addressed with human interaction.					
Total Calls Abandoned	A call or other type of contact that has been offered into a communications network or telephone system but is terminated by the person originating the contact before any conversation happens. These are the total calls during the Period that were abandoned waiting on human interaction.					
Percentage (%) Calls Abandoned	The total calls abandoned divided by total member calls making it into the queue during the Period multiplied by 100.					**<5%**

Monthly Managed Care Organization (MCO) Member Call Center Report (English Language Line)						
Average Speed of Answer/Wait Time	The average wait in queue experienced by all callers to an automatic call distributor group during a specified period. This calculation includes both calls delayed and those answered immediately.					
Percentage (%) of calls answered in 20 seconds	The total number of calls answered in 20 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					
Percentage (%) of calls answered in 30 seconds	The total number of calls answered in 30 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					**80%**
Percentage (%) of calls answered in 60 seconds	The total number of calls answered in 60 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					
Total Average Handle Time Duration (mm:ss)	The total time that a caller is on the phone for all calls during the Period divided by the total number of calls in minutes and seconds.					
Average Talk Time	The total time that callers spend on the phone with a live voice divided by the total number of calls in minutes and seconds.					
Average Hold Time	The total time that callers spend on hold prior to the interaction wit a live voice divided by the total number of calls in minutes and seconds.					**<3 minutes**
Average After Call Work (ACW)	Work immediately following a call or transaction. If the work must be completed before the agent can handle the next contact, then ACW is factored into average handle time. Work may involve keying activity codes, updating a database, filling out forms, or placing an associated outbound contact. The total time that the operator spends after the phone call writing notes and performing additional duties as a result of the phone call in minutes and seconds.					
Total Calls Placed on Hold	The total number of calls in the Period that were placed on hold.					
Total Calls Transferred Out	The total number of calls transferred out in the Period.					
Average Calls Received Per Day	Total number of calls that were received in the Period divided by the total days in the Period.					
Staff on Phones	Total number of staff manning the phones during the reporting Period.					
Peak Staffing	Total number of staff manning the phones during peak call center volume during the reporting Period.					
Occupancy Rate	The percentage of logged-in and available time that an agent spends in active contact handling (i.e., on incoming calls, in wrap-up activities, on outbound calls) versus in the idle, waiting state. Occupancy levels generally should not exceed 90 percent.					

Member Call Center – Spanish Language Line

Monthly Managed Care Organization (MCO) Member Call Center Report (Spanish Language Line)						
Report Date: (mm/dd/yyyy)						
Metric	**Definition of Metric**	**Current Year/ Current Month Totals**	**Previous Year/ Current Month Totals**	**Current Fiscal Year to Date Totals**	**Previous Fiscal Year to Date Totals**	**Performance Metrics**
Total Member Calls	The total number of Member Calls in the reporting period.					
Total Blocked Calls	A blocked call is one that cannot be completed because of a busy condition. The total number of blocked calls in the reporting month.					
Percentage (%) Blocked Calls	The total calls blocked divided by total member calls multiplied by 100.					
Calls handled by Interactive Voice Response (IVR) System	An interactive voice response (IVR) unit is a device that automates retrieval and processing of information by phone using touchtone signaling or voice recognition to access information residing on a server. The response may be given by a recorded human voice or a synthesized (computerized) voice. IVRs are used in applications such as "bank by phone" or "check on my order," which distribute information and collect transaction information. The total number of calls handled by the IVR system that did not require human intervention.					
Percentage (%) of Member Calls Passing Directly to the IVR	Total number of calls that went directly to the IVR system divided by total member calls multiplied by 100.					
Total Calls Requiring Callback/Messaging	The total number of calls during the periodthat required callback as a result of the initial call being sent to a voice messaging system. This may occur for many reasons but examples include those calls diverted due to high call volume and no operator availability or after hours messages.					
Total Calls making it to Operator Queue	These are the total calls during the periodthat made it into the Queue for human interaction. The calls that could not be assisted by the IVR or did not want to use the IVR system.					
Total Calls Answered in Queue	These are the total calls during the periodthat were answered and addressed with human interaction.					
Total Calls Abandoned	A call or other type of contact that has been offered into a communications network or telephone system but is terminated by the person originating the contact before any conversation happens. In an outboundcalling scenario, an abandoned call refers to a call that is disconnected by the automated dialer once live contact is detected but no agent is available to take the call. These are the total calls during the periodthat were abandoned waiting on human interaction.					
Percentage (%) Calls Abandoned	The total calls abandoned divided by total calls making it into the queue during the periodmultiplied by 100.					**<5%**
Average Time to Abandon in Seconds	The total number of seconds at the point where a call becomes abandonded divided by the total number of abandonded calls multiplied by 100.					

Monthly Managed Care Organization (MCO) Member Call Center Report (Spanish Language Line)						
Average Speed of Answer/Wait Time	The average wait in queue experienced by all callers to an automatic call distributor group during a specified period. This calculation includes both calls delayed and those answered immediately.					
Percentage (%) of calls answered in 20 seconds	The total number of calls answered in 20 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					
Percentage (%) of calls answered in 30 seconds	The total number of calls answered in 30 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					**80%**
Percentage (%) of calls answered in 60 seconds	The total number of calls answered in 60 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					
Total Average Handle Time Duration (mm:ss)	The total time that a caller is on the phone for all calls during the perioddivided by the total number of calls in minutes and seconds.					
Average Talk Time	The total time that callers spend on the phone with a live voice divided by the total number of calls in minutes and seconds.					
Average Hold Time	The total time that callers spend on hold prior to the interaction wit a live voice divided by the total number of calls in minutes and seconds.					**<3 minutes**
Average After Call Work (ACW)	Work immediately following a call or transaction. If the work must be completed before the agent can handle the next contact, then ACW is factored into average handle time. Work may involve keying activity codes, updating a database, filling out forms, or placing an associated outbound contact. The total time that the operator spends after the phone call writing notes and performing additional duties as a result of the phone call in minutes and seconds.					
Total Calls Placed on Hold	The total number of calls in the periodthat were placed on hold.					
Total Calls Transferred Out	The total number of calls transferred out in the month.					
Average Calls Received Per Day	Total number of calls that were received in the perioddivided by the total days in the month.					
Staff on Phones	Total number of staff manning the phones during the reporting month.					
Peak Staffing	Total number of staff manning the phones during peak call center volume during the reporting month.					
Occupancy Rate	The percentage of logged-in and available time that an agent spends in active contact handling (i.e., on incoming calls, in wrap-up activities, on outbound calls) versus in the idle, waiting state. Occupancy levels generally should not exceed 90 percent.					

Provider Call Center

Monthly Managed Care Organization (MCO) Provider Call Center Report						
Metric	**Definition of Metric**	**Current Year/ Current Month Totals**	**Previous Year/ Current Month Totals**	**Current Fiscal Year to Date Totals**	**Previous Fiscal Year to Date Totals**	**Performance Metrics**
Total Provider Calls	The total number of Provider Calls in the reporting period.					
Total Blocked Calls	A blocked call is one that cannot be completed because of a busy condition. The total number of blocked calls in the reporting period.					
Percentage (%) Blocked Calls	The total calls blocked divided by total Provider calls multiplied by 100.					
Calls handled by Interactive Voice Response (IVR) System	An interactive voice response (IVR) unit is a device that automates retrieval and processing of information by phone using touchtone signaling or voice recognition to access information residing on a server. The response may be given by a recorded human voice or a synthesized (computerized) voice. IVRs are used in applications such as "bank by phone" or "check on my order," which distribute information and collect transaction information. The total number of calls handled by the IVR system that did not require human intervention.					
Percentage (%) of Provider Calls Passing Directly to the IVR	Total number of calls that went directly to the IVR system divided by total Provider calls multiplied by 100.					
Total Calls Requiring Callback/Messaging	The total number of calls during the periodthat required callback as a result of the initial call being sent to a voice messaging system. This may occur for many reasons but examples include those calls diverted due to high call volume and no operator availability or after hours messages.					
Total Calls making it to Operator Queue	These are the total calls during the periodthat made it into the Queue for human interaction. The calls that could not be assisted by the IVR or did not want to use the IVR system.					
Total Calls Answered in Queue	These are the total calls during the periodthat were answered and addressed with human interaction.					
Total Calls Abandoned	A call or other type of contact that has been offered into a communications network or telephone system but is terminated by the person originating the contact before any conversation happens. In an outboundcalling scenario, an abandoned call refers to a call that is disconnected by the automated dialer once live contact is detected but no agent is available to take the call. These are the total calls during the periodthat were abandoned waiting on human interaction.					
Percentage (%) Calls Abandoned	The total calls abandoned divided by total calls making it into the queue during the periodmultiplied by 100.					**<5%**
Average Time to Abandon in Seconds	The total number of seconds at the point where a call becomes abandonded divided by the total number of abandonded calls multiplied by 100.					

Monthly Managed Care Organization (MCO) Provider Call Center Report						
Average Speed of Answer/Wait Time	The average wait in queue experienced by all callers to an automatic call distributor group during a specified period. This calculation includes both calls delayed and those answered immediately.					
Percentage (%) of calls answered in 20 seconds	The total number of calls answered in 20 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					
Percentage (%) of calls answered in 30 seconds	The total number of calls answered in 30 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					**80%**
Percentage (%) of calls answered in 60 seconds	The total number of calls answered in 60 seconds or less from the queue divided by the total number of calls in the queue system multiplied by 100.					
Total Average Handle Time Duration (mm:ss)	The total time that a caller is on the phone for all calls during the perioddivided by the total number of calls in minutes and seconds.					
Average Talk Time	The total time that callers spend on the phone with a live voice divided by the total number of calls in minutes and seconds.					
Average Hold Time	The total time that callers spend on hold prior to the interaction wit a live voice divided by the total number of calls in minutes and seconds.					**<3 minutes**
Average After Call Work (ACW)	Work immediately following a call or transaction. If the work must be completed before the agent can handle the next contact, then ACW is factored into average handle time. Work may involve keying activity codes, updating a database, filling out forms, or placing an associated outbound contact. The total time that the operator spends after the phone call writing notes and performing additional duties as a result of the phone call in minutes and seconds.					
Total Calls Placed on Hold	The total number of calls in the periodthat were placed on hold.					
Total Calls Transferred Out	The total number of calls transferred out in the month.					
Average Calls Received Per Day	Total number of calls that were received in the perioddivided by the total days in the month.					
Staff on Phones	Total number of staff manning the phones during the reporting month.					
Peak Staffing	Total number of staff manning the phones during peak call center volume during the reporting month.					
Occupancy Rate	The percentage of logged-in and available time that an agent spends in active contact handling (i.e., on incoming calls, in wrap-up activities, on outbound calls) versus in the idle, waiting state. Occupancy levels generally should not exceed 90 percent.					

<u>Section 5.4.5.1: Care Management Report:</u> The MCO must submit the following report monthly to indicate its members currently receiving care management during the month.

Monthly Case Management Report

MCO Name: MCO Number:

Report Date: (mm/dd/yyyy)

Risk Level: L= Low; M=Moderate; H=High

Type of Care Management: Please indicate the type of care management received (i.e., phone, home visits, visit at other location, other)

Risk Stratification Methodology: Please define method of stratification used to assess risk.

Medicaid ID	Last Name	First Name	Member Risk Score	Risk Level	Type of Care Management Received	Case Management begin date	Case Management End Date (if applicable)

Section 6.3.1 – 6.3.3.3: Provider Network Report: This report must be submitted to the agencies contracted enrollment broker and to SCDHHS (by the third Thursday of every month). For SCDHHS the file should be named as follows:

- Example: scPRTCC20150626.dat
- Explanation: sc for South Carolina, PR for Provider, the 3 letter ***health plan code*** can be found on the 'health plans' tab of the Maximus data dictionary (ADV, WLC, SEL, TCC, BLU, MOL), and the date created format is yyyymmdd

The report should be placed in the MCO's SharePoint 'PCMH NCQA Data' library in the 'Network Provider Files' section.

MAXIMUS Provider File Format

Version 27

* Full postive file

* Fixed form length

FILE HEADER RECORD				
Field #	**Common Name**	**Field Definition**	**Table Reference/Comments**	**Values**
1	Record identifer	9(3)	Constant "001" denotes file header	
2	Create date	X(08)	format is yyyymmdd	
3	File name	X(20)	See Health Plans tab	See Health Plans tab
4	Total provider records	9(6)	no decimal	

FILE PROVIDER RECORD							Companion Guide Reference				
Field #	**Common Name**	**Field Definition**	**Required ?**	**Values**	**Start**	**Length**	**Loop**	**SEG ID**	**Element**	**Industry Name**	**Comment**
1	Health Plan Code	X(12)	Y		1	12					See Health Plans tab - Health Plan Code (alphanumeric eyecatcher) Column
2	Provider County Code (location)	X(02)	Y		13	2	2300	N4/R-69	N406	Location Identification Code	For in-state providers, enter a valid SC county code (see county values tab). For out-of-state providers servicing SC Medicaid members, enter any of the following: the valid SC county code for the primary SC county serviced or the value of '00' or the value of '60' for Georgia counties or the value of '62' for North Carolina counties.
3	PCP Indicator	X(01)	Y	Y/N	15	1					
4	Group Indicator	X(01)	Y	"1"-Person "2"-Non-Person Entity	16	1					
5	Groupname	X(35)			17	35					
6	Medicaid Provider Indicator	X(01)	Y	"1"- Medicaid provider "2"- Non-Medicaid provider	52	1					
7	Medicaid Provider ID/Non Medicaid Unique Provider ID	X(12)			53	12	2300	HD/R-130	HD04	Plan Coverage Description	Only relevent when Field #6 = 1
8	Provider Name, Last	X(35)	Y		65	35	2300	NM1/R-141	NM103	Provider Last or Organization Name	
9	Provider Name, First	X(15)			100	15	2300	NM1/R-141	NM104	Provider First Name	
10	Provider Name, Middle Initial	X(01)			115	1	2300	NM1/R-141	NM105	Provider Middle Initial	
11	Provider Name, Suffix	X(05)			116	5	2300	NM1/R-141	NM107	Provider Name Suffix	
12	Provider Title Name	X(05)			121	5					
13	Provider SSN	X(09)			126	9					
14	Provider NPI	X(10)			135	10					
15	Health Plan Provider ID	X(15)	Y		145	15	2300	NM1/R-142	NM109	Provider Identifier	
16	Provider Address Line 1 (location)	X(50)	Y		160	50					
17	Provider Address Line 2 (location)	X(50)			210	50					
18	Provider City (location)	X(20)	Y		260	20					
19	Provider State Code (location)	X(02)	Y		280	2					
20	Provider Zip Code (location)	X(09)	Y		282	9					
21	Provider Phone Num.(location)	X(10)			291	10					
22	Provider Fax Num (location)	X(10)			301	10					
23	Provider Email Address (location)	X(50)			311	50					
24	Provider Address Line 1 (mailing)	X(50)			361	50					
25	Provider Address Line 2 (mailing)	X(50)			411	50					
26	Provider City (mailing)	X(20)			461	20					
27	Provider State Code (mailing)	X(02)			481	2					
28	Provider Zip Code (mailing)	X(09)			483	9					
29	Provider County Code (mailing)	X(02)			492	2					
30	Provider Phone Num.(mailing)	X(10)			494	10					
31	Provider Fax Num. (mailing)	X(10)			504	10					
32	Language 1	X(03)			514	3					
33	Language 2	X(03)			517	3					
34	Language 3	X(03)			520	3					
35	Language 4	X(03)			523	3					
36	Language 5	X(03)			526	3					
37	Language 6	X(03)			529	3					
38	Language 7	X(03)			532	3					
39	Gender	X(01)			535	1					
40	New Patient Indicator	X(01)		See Plan - New Patient Ind tab	536	1					
41	Provider Capacity	9(06)	For MHN plans only		537	6					
42	Specialty Segment Counter	9(02)			543	2					
43	Provider Specialty 1	X(02)	Y		545	2					
44	Provider Specialty Effective Date 1	X(10)			547	10					
45	Provider Specialty End Date 1	X(10)			557	10					
46	Provider Specialty 2	X(02)			567	2					
47	Provider Specialty Effective Date 2	X(10)			569	10					
48	Provider Specialty End Date 2	X(10)			579	10					
49	Provider Specialty 3	X(02)			589	2					

50	Provider Specialty Effective Date 3	X(10)			591	10					
51	Provider Specialty End Date 3	X(10)			601	10					
52	Provider Specialty 4	X(02)			611	2					
53	Provider Specialty Effective Date 4	X(10)			613	10					
54	Provider Specialty End Date 4	X(10)			623	10					
55	Provider Specialty 5	X(02)			633	2					
56	Provider Specialty Effective Date 5	X(10)			635	10					
57	Provider Specialty End Date 5	X(10)			645	10					
58	Provider Specialty 6	X(02)			655	2					
59	Provider Specialty Effective Date 6	X(10)			657	10					
60	Provider Specialty End Date 6	X(10)			667	10					
61	Provider Specialty 7	X(02)			677	2					
62	Provider Specialty Effective Date 7	X(10)			679	10					
63	Provider Specialty End Date 7	X(10)			689	10					
64	Provider Specialty 8	X(02)			699	2					
65	Provider Specialty Effective Date 8	X(10)			701	10					
66	Provider Specialty End Date 8	X(10)			711	10					
67	Provider Specialty 9	X(02)			721	2					
68	Provider Specialty Effective Date 9	X(10)			723	10					
69	Provider Specialty End Date 9	X(10)			733	10					
70	Provider Specialty 10	X(02)			743	2					
71	Provider Specialty Effective Date 10	X(10)			745	10					
72	Provider Specialty End Date 10	X(10)			755	10					
73	Minimum Age Limit of Care	X(02)		0 - 99	765	2					
74	Maximum Age Limit of Care	X(02)		0 - 99	767	2					
75	Handicapped Accessible	X(01)		Y or N	769	1					
76	Office Hours Monday	X(01)		1=Monday	770	1					
77	Office Hours Monday Open Time	X(04)		XXYY XX = 00-23 YY = 00-59	771	4					Value of '2400' is not a valid entry
78	Office Hours Monday Close Time	X(04)		XXYY XX = 00-23 YY = 00-59	775	4					Value of '2400' is not a valid entry
79	Office Hours Tuesday	X(01)		2=Tuesday	779	1					
80	Office Hours Tuesday Open Time	X(04)		XXYY XX = 00-23 YY = 00-59	780	4					Value of '2400' is not a valid entry
81	Office Hours Tuesday Close Time	X(04)		XXYY XX = 00-23 YY = 00-59	784	4					Value of '2400' is not a valid entry
82	Office Hours Wednesday	X(01)		3= Wednesday	788	1					
83	Office Hours Wednesday Open Time	X(04)		XXYY XX = 00-23 YY = 00-59	789	4					Value of '2400' is not a valid entry
84	Office Hours Wednesday Close Time	X(04)		XXYY XX = 00-23 YY = 00-59	793	4					Value of '2400' is not a valid entry
85	Office Hours Thursday	X(01)		4= Thursday	797	1					
86	Office Hours Thursday Open Time	X(04)		XXYY XX = 00-23 YY = 00-59	798	4					Value of '2400' is not a valid entry
87	Office Hours Thursday Close Time	X(04)		XXYY XX = 00-23 YY = 00-59	802	4					Value of '2400' is not a valid entry
88	Office Hours Friday	X(01)		5= Friday	806	1					
89	Office Hours Friday Open Time	X(04)		XXYY XX = 00-23 YY = 00-59	807	4					Value of '2400' is not a valid entry
90	Office Hours Friday Close Time	X(04)		XXYY XX = 00-23 YY = 00-59	811	4					Value of '2400' is not a valid entry
91	Office Hours Saturday	X(01)		6= Saturday	815	1					
92	Office Hours Saturday Open Time	X(04)		XXYY XX = 00-23 YY = 00-59	816	4					Value of '2400' is not a valid entry
93	Office Hours Saturday Close Time	X(04)		XXYY XX = 00-23 YY = 00-59	820	4					Value of '2400' is not a valid entry
94	Office Hours Sunday	X(01)		7= Sunday	824	1					
95	Office Hours Sunday Open Time	X(04)		XXYY XX = 00-23 YY = 00-59	825	4					Value of '2400' is not a valid entry
96	Office Hours Sunday Close Time	X(04)		XXYY XX = 00-23 YY = 00-59	829	4					Value of '2400' is not a valid entry
97	Provider Type	X(02)		See Provider Types tab	833	2					
98	Filler	X(07)			835	7					
99	Restriction2	X(09)		For later	842	9					
100	Restriction3	X(09)		For later	851	9					
101	Restriction4	X(09)		For later	860	9					
102	Restriction5	X(09)		For later	869	9					
103	Restriction6	X(09)		For later	878	9					
104	New Patient Indicator Override	X(01)		Y or N	887	1					
105	FTE	X(03)	See Comment	0 - 100	888	3					This field is required for cases 2&3 below, causing the record to conist of 891 total characters. Record length must follow one of these conventions or provider file import will misinterpret meanings of records and cause many errors: 1. **888 characters long records ending in a Carriage Return Line Feed (CRLF)** (This is used if the file name satisfies either condition: 1.contains "kmhpselecthealth-sc" but not "PR1000" 2.contains "bluechoicesc-sc") 2. **891 characters long records ending in a Line Feed (LF).** (This is used if the file name contains the string "centene-sc") 3. **891 characters long records ending in a Carriage Return Line Feed (CRLF)** (This is used for all remaining provider files – where they don't fall into the file names listed above)

FILE TRAILER RECORD				
Field #	**Common Name**	**Field Definition**	**Table Reference/Comments**	**Values**
1	Record identifier	9(3)	constant "999" denotes file trailer	
2	Total provider records	9(6)	no decimal	

New Patient Indicator

This code indicates how MAXIMUS will accept Enrollments to the Provider

Value	Description	Allow Choice via			New Patient Indicator Override Applicable?
		Member Choice	Auto Assign	Family Assigned*	
1	Accepts All	Yes	Yes	N/A	No
2	Accepts None	No	No	No	Yes
3	Member Choice Only	Yes	No	N/A	No
4	Member Choice / Family	Yes	No	Yes	No
5	Auto Assign / Family	No	Yes	Yes	No
6	Auto Assign Only	No	Yes	N/A	No
7	Family Assign Only	Yes	Yes	Yes	No

* Family Assigned method is used when another member of the family already has this PCP Provider. If N/A, is not taken into account, Yes must already have family member, No does

Explanation of the 'New patient Indicator' values

1 - Accepts All: This is the default value for the new patient indicator. If the value is 1 for this field then this provider accepts new member choices as well as new auto assigned members. There is no restriction on the selections.

2 - Accepts None: The provider does not accept new members either through member selections or by auto assignments.

3 - Member Choice Only: The provider only accepts selections made by member choice. The provider does not accept any auto assigned members.

4 - Member Choice with Family: The provider accepts only selections by member choice only if a member of the family is already enrolled with the provider. The provider does not accept any auto assignments.

5 - Auto assignment with Family: The provider accepts only auto assignments if a member of the family is already enrolled with the provider. The provider does not accept any member choices. This is an unlikely scenario, but has been added as a choice for future changes.

6 - Auto assignment only: The provider only accepts auto assigned members.
The provider does not accept any selections made by member choice. This is an unlikely scenario, but has been added as a choice for future changes.

7 - Family Assign Only: The provider accepts both auto assigned members and member choices only if a member of the family is already enrolled with the provider.

Provider Languages

Languages spoken by the provider.

Code	Description
ARA	Arabic
ARM	Armenian
CHI	Chinese
ENG	English
FRE	French
GER	German
GRE	Greek
GUJ	Gujarati
HAT	Haitian
HIN	Hindi
HMN	Hmung
ITA	Itialian
JPN	Japanese
KHM	Kmer
KOR	Korean
LAO	Laotian
MAN	Mandarin
PER	Persian
POL	Polish
POR	Portuguese
RUS	Russian
SGN	American Sign Language
SMO	Samoan
SPA	Spanish
TGL	Tagalog
TUR	Turkish
UKR	Ukranian
VIE	Vietnamese
YID	Yiddish
ZZZ	Other

CrossWalk to Old Values

Old	New	Description
AR	ARA	Arabic
HY	ARM	Armenian
CH	CHI	Chinese
EN	ENG	English
FR	FRE	French
GE	GER	German
GR	GRE	Greek
GU	GUJ	Gujarati
HT	HAT	Haitian
HI	HIN	Hindi
IT	ITA	Italian
JA	JPN	Japanese
KM	KHM	Khmer
KO	KOR	Korean
LA	LAO	Laotian
FA	PER	Persian
PL	POL	Polish
PO	POR	Portuguese
RU	RUS	Russian
SL	SGN	American Sign Language
SM	SMO	Samoan
ES	SPA	Spanish
TL	TGL	Tagalog
TR	TUR	Turkish
UK	UKR	Ukranian
VI	VIE	Vietnamese
YI	YID	Yiddish

Crosswalk to DHHS Codes

DHHS	Code	Language
E	ENG	English
S	SPA	Spanish
M	MDR	Mandarin
P	POR	Portuguese
V	VIE	Vietnamese
H	HIN	Hindi
K	KOR	Korean
C	CHI	Chinese
G	GUJ	Gujarati
R	RUS	Russian
A	ARA	Arabic
T	TUR	Turkish
B	POL	Polish
D	PER	Persian
F	FRE	French
I	ITA	Italian
J	JPN	Janenese
L	LAO	Laotian
N	HMN	Hmung
O	ENG	Other
Q	GER	German
U	UKR	Ukranian
W	ARM	Armenian
X	KHM	Khmer
Y	YID	Yiddish
Z	GRE	Greek
1	SMO	Samoan
2	HAT	Haitian
3	SGN	American Sign Language
4	CHI	Chinese
5	TGL	Tagalog

Health Plans

A code indicating each Health Plan

Health Plan Code	Health Plan Name	Status	**Health Plan Code (alphanumeric eyecatcher)**	Provider File Delivery Date	Typical Provider File Name (After EB receives, MOVEIT will prepend a date/time stamp before processing)	Note-Pentaho	
MCO							
HM3400	AdviCare	Active - combined with PRIME	ADV	No restrictions	royal-scPRADV20150601.dat	PRADV	
HM3800	WellCare	Active?	WLC	No restrictions	scwellcare-wellcare-scPRWLC20150525.dat	PRWLC	
HM1000	First Choice by Select Health of South Carolina	Active	SEL	No restrictions	kmhpselecthealth-scPRSEL20150526.dat	PRSEL	
HM2200	Absolute Total Care	Active	TCC	No restrictions	centene-scPRTCC20150527.dat	PRTCC	
HM3200	BlueChoice HealthPlan Medicaid	Active	BLU	No restrictions	bluechoicesc-scPRBLU20150528.dat		
HM3600	Molina HealthCare of SC	Active	MOL	No restrictions	scPRMOL20150526.dat	PRMOL2	
PCM120	South Carolina Solutions	Not Active for Provider files Active as PCM140	SCS	No restrictions	chsamerica-scPRSCS20131224.dat	chsamerica	
PRIME							
PR3400	AdviCare Advocate	Active - combined with MCO	PR3400	No restrictions	royal-scPRADV20150601.dat	PRADV	
PR1000	First Choice VIP Care Plus	Active	PR1000	No restrictions	kmhpPRselecthealth-scPR100020150430.dat	PR1000	Select Health
PR3600	Molina Dual Options	Active	PR3600	No restrictions	scPRMOLMMP20150526.dat	PRMOLMMP	
PR2200	Absolute Total Care	Active	PR2200	No restrictions	centene-scPRTCS20150501.dat	PRTCS	

Provider Specialties

If a provider does not have a PCP Specialty code, the PCP Status will be set to N

A code indicating a provider's certified medical specialty.

Code	Specialty	PCP	Displayed As*	Display on Web Site
00	NO SPECIFIC MEDICAL SPECIALTY			No
01	THERAPIST/MULTIPLE SPECIALTY			No
02	ALLERGY AND IMMUNOLOGY			Allergist
03	ANESTHESIOLOGY			Anesthesiologist
04	AUDIOLOGY			Audiologist
05	CARDIOVASCULAR DISEASES			Cardiologist
06	MIDWIFE			Midwife
07	CHIROPRACTIC			Chiropractor
08	DENTISTRY			Dentist
09	DERMATOLOGY			Dermatologist
10	EMERGENCY MEDICINE			No
11	ENDOCRINOLOGY AND METAB.			Endocrinologist
12	FAMILY PRACTICE	Y	Family Practitioner	Family Practitioner
13	GASTROENTEROLOGY			Gastroenterologist
14	GENERAL PRACTICE	Y	General Practitioner	General Practitioner
15	GERIATRICS			Geriatric Provider
16	GYNECOLOGY	Y	OB/GYN	OB/GYN
17	HEMATOLOGY			Hematologist
18	INFECTIOUS DISEASES			No
19	INTERNAL MEDICINE	Y	Internal Medicine	Internist
20	PVT MENTAL HEALTH			Private Mental Health Facility
21	NEPHROLOGY/ESRD			Nephrologist
22	NEUROLOGY			Neurologist
23	NEUROPATHOLOGY			No
24	NUCLEAR MEDICINE			No
25	NURSE ANESTHETIST			No
26	OBSTETRICS	Y	OB/GYN	OB/GYN
27	OBSTETRICS AND GYNECOLOGY	Y	OB/GYN	OB/GYN
28	SC DEPT OF MENTAL HEALTH			No
29	OCCUPATIONAL MEDICINE			No
30	ONCOLOGY			Oncologist
31	OPHTHALMOLOGY			Ophthalmologist
32	OSTEOPATHY	Y		Osteopath
33	OPTICIAN			No
34	OPTOMETRY			No
35	ORTHODONTICS			No
36	OTORHINOLARYNGOLOGY			Ear Nose & Throat
37	HOSPITAL PATHOLOGY			No
38	PATHOLOGY			No
39	PATHOLOGY, CLINICAL			No
40	PEDIATRICS	Y	Pediatrician	Pediatrician
41	PEDIATRICS, ALLERGY		Pediatrician	No - Same as Code AA
42	PEDIATRICS, CARDIOLOGY		Pediatrician	No - Same as Code AA
43	PEDIODONTICS			No
44	INDEPENDENT LAB - PRICING ONLY			No
45	PHYSICAL MEDICINE & REHABILITATION			No
46	XRAY - LAB - PRICING ONLY			No
47	PODIATRY			Podiatrist
48	PSYCHIATRY			Psychiatrist
49	PSYCHIATRY, CHILD			Psychiatrist

Provider Specialties

If a provider does not have a PCP Specialty code, the PCP Status will be set to N

A code indicating a provider's certified medical specialty.

Code	Specialty	PCP	Displayed As*	Display on Web Site
50	FEDERALLY QUALIFIED HEALTH CLINICS (FQHC)	Y	Federally Qualified Health Center	Federally Qualified Health Center
51	SC DEPT OF HEALTH & ENVIRON CONTROL		Public Health Department	Public Health Department
52	PULMONARY MEDICINE			Pulmonologist
53	NEONATOLOGY		Pediatrician	Neonatologist
54	RADIOLOGY			Radiologist
55	RADIOLOGY, DIAGNOSTIC			No
56	RADIOLOGY, THERAPEUTIC			No
57	RHEUMATOLOGY			Rheumatologist
58	FEDERALLY FUNDED HEALTH CLINICS (FFHC		Community Health Center	Community Health Center
59	SUPPLIER (DME)			No ??
60	HOME HEALTH - PRICING ONLY			No
61	SURGERY, CARDIOVASCULAR			Surgery - Cardiovascular
62	SURGERY, COLON AND RECTAL			Surgery - Colon and Rectal
63	SURGERY, GENERAL			Surgery - General
64	AMBULANCE - PRICING ONLY			No
65	SURGERY, NEUROLOGICAL			Surgery - Neurological
66	SURGERY, ORAL (DENTAL ONLY)			Surgery - Oral
67	SURGERY, ORTHOPEDIC			Surgery - Orthopedic
68	SURGERY, PEDIATRIC		Pediatrician	Surgery - Pediatric
69	SURGERY, PLASTIC			Surgery - Plastic
70	SURGERY, THORACIC			Surgery - Thoracic
71	SURGERY, UROLOGICAL			Surgery - Urology
72	CLINIC SCREENERS - PRICING ONLY			No
73	PHYSICIAN SCREENERS - PRICING ONLY			No
74	PROSTHETICS & ORTHOTICS PRICE ONLY			No
75	INDIVIDUAL TRANS - PRICING ONLY			No
76	CAP - PRICING ONLY			No
77	CLTC			No
78	MULTIPLE SPECIALTY GROUP			No
79	PHYSICIAN ASSISTANT (ENCOUNTER DATA ONLY)			No
80	OUTPATIENT-PRICING ONLY			No
81	OUTPATIENT-ALTERNATE PRICING SPECIALTY			No
82	PSYCHOLOGIST			Psychologist
83	SOCIAL WORKER			Social Worker
84	SPEECH THERAPIST			Speech Therapist
85	PHYSICAL/OCCUPATIONAL THERAPIST			Physical Therapist
86	NURSE PRACTITIONER & PHYSICIAN ASSISTANT	Y	Certified Nurse Practitioner	Certified Nurse Practitioner
87	OCCUPATIONAL THERAPIST			Occupational Therapist
88	HOSPICE			No
89	CORF			No
90	ALCOHOL & SUBSTANCE ABUSE			No
91	MENTAL RETARDATION			No
92	SC CONTINUUM OF CARE			No
93	AMBULATORY SURGERY			No
94	DIABETES EDUCATOR			No
95	DEVELOPMENTAL REHABILITATION			No
96	FAMILY PLANNING, MATERNAL & CHILD HEALTH			No
97	RURAL HEALTH CLINICS (RHC)	Y	Rural Health Clinic (RHCs)	Rural Health Clinic
98	PRIVATE DUTY NURSING			No
99	PEDIATRIC NURSE PRACTITIONER		Certified Nurse Practitioner	Certified Nurse Practitioner
AA	PEDIATRIC SUB-SPECIALIST			Pediatric Specialists

Provider Gender Code

This code identifies the provider's genc

Value	Name	
F	Female	
M	Male	
U	Unspecified	

County Codes Crosswalk

These are the valid codes for counties.

Code	Name
01	Abbeville
02	Aiken
03	Allendale
04	Anderson
05	Bamberg
06	Barnwell
07	Beaufort
08	Berkeley
09	Calhoun
10	Charleston
11	Cherokee
12	Chester
13	Chesterfield
14	Clarendon
15	Colleton
16	Darlington
17	Dillon
18	Dorchester
19	Edgefield
20	Fairfield
21	Florence
22	Georgetown
23	Greenville
24	Greenwood
25	Hampton
26	Horry
27	Jasper
28	Kershaw
29	Lancaster
30	Laurens
31	Lee
32	Lexington
33	Mccormick
34	Marion
35	Marlboro
36	Newberry
37	Oconee
38	Orangeburg
39	Pickens
40	Richland
41	Saluda
42	Spartanburg
43	Sumter
44	Union
45	Williamsburg
46	York
00	Non-SC county
60	Georgia
62	North Carolina

Old	New	Name
001	01	Abbeville
003	02	Aiken
005	03	Allendale
007	04	Anderson
009	05	Bamberg
011	06	Barnwell
013	07	Beaufort
015	08	Berkeley
017	09	Calhoun
019	10	Charleston
021	11	Cherokee
023	12	Chester
025	13	Chesterfield
027	14	Clarendon
029	15	Colleton
031	16	Darlington
033	17	Dillon
035	18	Dorchester
037	19	Edgefield
039	20	Fairfield
041	21	Florence
043	22	Georgetown
045	23	Greenville
047	24	Greenwood
049	25	Hampton
051	26	Horry
053	27	Jasper
055	28	Kershaw
057	29	Lancaster
059	30	Laurens
061	31	Lee
063	32	Lexington
065	33	Mccormick
067	34	Marion
069	35	Marlboro
071	36	Newberry
073	37	Oconee
075	38	Orangeburg
077	39	Pickens
079	40	Richland
081	41	Saluda
083	42	Spartanburg
085	43	Sumter
087	44	Union
089	45	Williamsburg
091	46	York

Provider Types

These are the valid facility codes.

Value	Name
00	Nursing Home
01	Inpatient Hospital
02	Outpatient Hospital
04	Mental Health (PVT)
10	Mental/Rehab
15	Buy-In
16	EPSDT
19	Other Medical Prof
20	Physician,Osteopath Ind
21	Physician,Osteopath Grp
22	Medical Clinics
30	Dentist, Ind
31	Dental, Grp
32	Opticians
33	Optometrist, Ind
34	Optometrist, Grp
35	Podiatrist, Ind
36	Podiatrist, Grp
37	Chiropractor, Ind
38	Chiropractor, Grp
41	Optician, Grp
60	Home Health Agency
61	CLTC, Individual
62	CLTC, Group
70	Pharmacy
76	Durable Medical Equipment
80	Independent Laboratory
81	X-Ray
82	Ambulance Service
84	Medical Transportation
85	CAP Agencies
89	MCCA - Medicare Catastrophic Coverage Act (Social Workers)
96	Miscellaneous - Not Used
97	DUR - Unspecified - Not Used
98	Without Valid Prov Type - Not Used

Section 7.3.1.1: Dual Medicare/Medicaid Report: The MCO will receive this file on a monthly basis which will include all members that received retro-active Medicare eligibility during the month. SCDHHS will perform gross-level adjustments to the MCO monthly for all members on this report to accurately pay premiums up to a year in arrears.

MONTHLY DUAL MEDICARE-MEDICAID ELIGIBLE REPORT

CCN	Check Date	Check Number	Individual Number	Individual Medicare Number	Premium Month	Provider Name	Provider Number	Total Claim Charge	Total Amt. Paid per Claim	Amount that Should have Paid Originally	Difference Between Actual and Amount that should be paid	Paid Date	Premium Date	Recipient First Name	Recipient Last Name

Section 7.3.1.1: Deceased Members Receiving Premium Payment: The MCO will receive this file on a monthly basis which will include all members that passed away but received premium payment in error. SCDHHS will perform gross-level adjustments to the MCO monthly for all members on this report to accurately pay premiums up to a year in arrears.

(MCO NAME) DECEASED MEMBERS THAT RECEIVED PREMIUM PAYMENTS IN ERROR

MEDICAID ID	DATE OF DEATH	PREMIUM DATE	RATE CELL	RATE DESCRIPTION	CLAIM ID	PROVIDER ID	PROVIDER NAME	CHECK DATE	PAID DATE	ADJUSTMENT TYPE CODE	ADJUSTMENT DESCRIPTION	N_Obs	CAPITATION AMOUNT PAID

Section 7.3.1.1: Patient Centered Medical Home (PCMH)

Completing the PCMH Form:

There are five (5) worksheet tabs to this report. Worksheet one (1) is a review of the instructions, worksheet two (2) is the spreadsheet utilized for providers in the application phase. Worksheet three (3) is utilized for level 1 PCMH providers, worksheet four (4) is for the level 2 PCMH providers, and worksheet five (5) is for the level 3 PCMH providers.

PCMH Application:

a. Please add those providers and their members that are still under application to the worksheet tab labeled Application.

b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.

c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

d. For anyone still in the application process you will need to include with their contracts a copy of the application and a defined timeline with an update provided quarterly. See appendix 5 of the P&P for more details.

These reports should be submitted on a monthly basis to ensure that SCDHHS and its contractor can reimburse the plans timely and accurately at the end of the quarter.

PCMH Application Template (Tab 2)

[Insert Plan Name] Fiscal Year *(insert year)* - 1st Quarter (July)															
Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

PCMH1 Worksheet:

a. Please add those providers and their members that are in PCMH1 status to the worksheet tab labeled PCMH1.

b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.

c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

PCMH Level I (tab 3)

[Insert Plan Name] Fiscal Year (*insert year*) - 1st Quarter (July)

Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

PCMH2 Worksheet:

a. Please add those providers and their members that are in PCMH2 status to the worksheet tab labeled PCMH2.

b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.

c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

PCMH Level II (tab 4)

[Insert Plan Name] Fiscal Year (*insert year*) - 1st Quarter (July)

Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

PCMH3 Worksheet:

a. Please add those providers and their members that are in PCMH3 status to the worksheet tab labeled PCMH3.

b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.

c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

PCMH Level III (tab 5)

[Insert Plan Name] Fiscal Year *(insert year)* - 1st Quarter (July)

Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

Section 10.9.1 through 10.9.1.4: Third Party Liability Reports (TPL) – MCOs must submit Five (5) Monthly Reports

1) **TPL Verification:** MCO report required for verification of Medicaid members identified as having TPL coverage that SCDHHS has not identified as having TPL coverage. This report is submitted via the departments FTP site.

2) **TPL Cost Avoidance: TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report.**
Tab 1 -- TPL Cost Avoidance (Professional CMS-1500): MCO report required for claims cost avoided during the month for professional services. Provide a total for columns "charge" and "amount cost avoided".

MCO Name		**(MCO Number)**							
Cost Avoidance Encounter Data				**(Claims rejecting for TPL)**					
For month ending _____									
For Professional Claims									
Medicaid Member ID	**First Name**	**Last Name**	**Beginning Date of Service**	**End Date of Service**	**Claim Processed Date**	**Provider NPI**	**Practice Specialty Description**	**Charge**	**Amount Cost Avoided**

Tab 2 -- TPL Cost Avoidance (UB Claims): MCO report required for claims cost avoided during the month for institutional services. Provide a total for columns "charge" and "amount cost avoided".

MCO Name		**(MCO Number)**							
Cost Avoidance Encounter Data				**(Claims rejecting for TPL)**					
For month ending _____									
For UB Claims									
Medicaid Member ID	**First Name**	**Last Name**	**Beginning Date of Service**	**End Date of Service**	**Claim Processed Date**	**Provider NPI**	**Practice Specialty Description**	**Charge**	**Amount Cost Avoided**

Tab 3 -- TPL Cost Avoidance (Drug Claims): MCO report required for claims cost avoided during the month for pharmacy services. Provide a total for columns “drug submit charge” and “amount cost avoided”.

MCO Name		**(MCO Number)**								
Cost Avoidance Encounter Data					**(Claims rejecting for TPL)**					
For month ending _____										
For Drug Claims										
Medicaid Member ID	**First Name**	**Last Name**	**Dispense Date**	**NDC**	**Product Description**	**Claim Processed Date**	**Provider NPI**	**Prescribing NPI**	**Drug Submit Charge**	**Amount Cost Avoided**

3) **TPL Coordination of Benefits (COB) Savings: TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report.**

Tab 1 -- TPL Coordination of Benefits Savings (Professional Claims): MCO report required for claims where savings was realized through partial payment by a third party insurer during the month for professional services. Provide a total for columns “claim charge”, “primary health insurance payment”, and “MCO claim paid amount”.

MCO Name		**(MCO Number)**										
Coordination of Benefits Savings (COB Savings)												
For month ending _____												
For Professional Claims												
Medicaid Member ID	**First Name**	**Last Name**	**Beginning Date of Service**	**End Date of Service**	**Claim Procesed Date**	**Provider NPI**	**Practice Specialty Description**	**Claim Charge**	**Primary Health Insurance Payment**	**Primary Health Insurance Carrier Code**	**MCO Claim Paid Amount**	

Tab 2 -- TPL Coordination of Benefits Savings (UB Claims): MCO report required for claims where savings was realized through partial payment by a third party insurer during the month for institutional services. Provide a total for columns “claim charge”, “primary health insurance payment”, and “MCO claim paid amount”.

MCO Name **(MCO Number)**

Coordination of Benefits Savings (COB Savings)

For month ending _____

For UB Claims

Medicaid Member ID	First Name	Last Name	Beginning Date of Service	End Date of Service	Claim Processed Date	Provider NPI	Practice Specialty Description	Claim Charge	Primary Health Insurance Payment	Primary Health Insurance Carrier Code	MCO Claim Paid Amount

Tab 3 -- TPL Coordination of Benefits Savings (Drug Claims): MCO report required for claims where savings was realized through partial payment by a third party insurer during the month for pharmacy services. Provide a total for columns “drug submit charge”, “primary health insurance payment”, and “MCO claim paid amount”.

MCO Name **(MCO Number)**

Coordination of Benefits Savings (COB Savings)

For month ending _____

For Drug Claims

Medicaid Member ID	First Name	Last Name	Dispense Date	NDC	Product Description	Claim Processed Date	Pharmacy NPI	Prescribing NPI	Drug Submit Charge	Primary Health Insurance Payment	Primary Health Insurance Carrier Code	MCO Claim Paid Amount

Cost Avoidance Cell Definitions

Cost Avoidance Reports Professional and UB Claims		
Cell Descriptor		**Definitions**
MCO Name		Name of the MCO submitting the report.
MCO Number		Medicaid assigned legacy ID of the MCO submitting the report to SCDHHS.
Medicaid Member ID		SCDHHS issued 10 digit Medicaid Identification Number for each beneficiary
First Name		Medicaid member first name that corresponds to the submitted Medicaid ID.
Last Name		Medicaid member last name that corresponds to the submitted Medicaid ID.
Beginning Date of Service		The providers first submitted date of service on the claim.
End Date of Service		The last date of service provided on the claim form.
Claim Processed Date		The date the MCO processed/denied the claim in question.
Provider NPI		The National Provider Identifier of the individual or group that submitted the claim in question.
Practice Specialty Description		The specialty of the provider where TPL related savings was realized. For example, oncology, radiology, laboratory, hospital
Charge		The total charge of the entire claim submitted by the provider that was cost avoided.
Amount Cost Avoided		Claims processed and denied by the MCO for Third Party Liability. The amount not paid because the claim was rejected.

Cost Avoidance Reports Pharmacy Claims		
Cell Descriptor		**Definitions**
Medicaid Member ID		SCDHHS issued 10 digit Medicaid Identification Number for each beneficiary
First Name		Medicaid member first name that corresponds to the submitted Medicaid ID.
Last Name		Medicaid member last name that corresponds to the submitted Medicaid ID.
Dispense Date		Date the prescription was filled and picked up
Drug Code		Universal product identifier for human drugs. The NDC number must be utilized for reporting purposes.
Product Description		The Drug Name that corresponds to the Drug
Claim Processed Date		The date the MCO processed/denied the claim in question.
Provider NPI		The National Provider Identifier of the individual or group that submitted the claim in question.
Prescribing NPI		The NPI of the prescribing provider.
Drug Submit Charge		The total charge of the drug claim submitted by the provider that was cost avoided.

Coordination of Benefit Cell Definitions

Coordination of Benefits Savings (COB Savings)		
Professional and UB Claims		
Cell Descriptor		**Definitions**
MCO Name		Name of the MCO submitting the report.
MCO Number		Medicaid assigned legacy ID of the MCO submitting the report to SCDHHS.
Coordination of Benefits Savings (COB Savings)		Claims that have TPL involvement. The Amount saved because primary health insurance paid on the claim.
Medicaid Member ID		SCDHHS issued 10 digit Medicaid Identification Number for each beneficiary
First Name		Medicaid member first name that corresponds to the submitted Medicaid ID.
Last Name		Medicaid member last name that corresponds to the submitted Medicaid ID.
Beginning Date of Service		The providers first submitted date of service on the claim.
End Date of Service		The last date of service provided on the claim form.
Claim Paid/Processed Date		The date the MCO paid/processed the claim in question.
Provider NPI		The National Provider Identifier of the individual or group that submitted the claim in question.
Practice Specialty Description		The specialty of the provider where TPL related savings was realized. For example, oncology, radiology, laboratory, hospital
Charge		The total charge of the entire claim submitted by the provider that was cost avoided.
Primary Health Insurance Payment		The amount that was paid by the primary health insurer, not Medicaid or the MCO.
Primary Health Insurance Carrier Code		SCDHHS utilizes 3 digit carrier codes for recognizing primary health insurers. Each Carrier is assigned a unique code that can be found at https://www.scdhhs.gov/resource/carrier-codes
MCO Claim Paid Amount		The total amount that was paid on the claim in question by the Medicaid MCO.

Pharmacy Claims		
Cell Descriptor		**Definitions**
Medicaid Member ID		SCDHHS issued 10 digit Medicaid Identification Number for each beneficiary
First Name		Medicaid member first name that corresponds to the submitted Medicaid ID.
Last Name		Medicaid member last name that corresponds to the submitted Medicaid ID.
Dispense Date		Date the prescription was filled and picked up
Drug Code		Universal product identifier for human drugs. The NDC number must be utilized for reporting purposes.
Product Description		The Drug Name that corresponds to the Drug
Claim Paid/Processed Date		The date the MCO processed/denied the claim in question.
Provider NPI		The National Provider Identifier of the individual or group that submitted the claim in question.
Prescribing NPI		The NPI of the prescribing provider.
Drug Submit Charge		The total charge of the drug claim submitted by the provider that was cost avoided.
Primary Health Insurance Payment		The amount that was paid by the primary health insurer, not Medicaid or the MCO.
Primary Health Insurance Carrier Code		SCDHHS utilizes 3 digit carrier codes for recognizing primary health insurers. Each Carrier is assigned a unique code that can
MCO Claim Paid Amount		The total amount that was paid on the claim in question by the Medicaid MCO.

4) **TPL Recoveries: TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report.**
Tab 1 -- TPL Recovery (Professional Claims CMS-1500): MCO report required for claims that were recovered during the month due to third party insurance coverage for professional services. Provide a total for column "amount recovered".

MCO Name (MCO Number)
Recovery Claims Data
For Month Ending _____

For Professional Claims

Medicaid Member ID	First Name	Last Name	Beginning Date of Service	End Date of Service	Claim Paid Date	Paid to Provider NPI	Practice Specialty Description	Line Submit Charge	Line Amount Paid	Date Billed to Carrier or Provider	Amount Recovered

Tab 2 -- TPL Recovery (UB Claims): MCO report required for claims that were recovered during the month due to third party insurance coverage for institutional services. Provide a total for column "amount recovered".

MCO Name (MCO Number)
Recovery Claims Data
For Month Ending _____

For UB Claims

Medicaid Member ID	First Name	Last Name	Beginning Date of Service	End Date of Service	Claim Paid Date	Paid to Provider NPI	Practice Specialty Description	Line Submit Charge	Line Amount Paid	Date Billed to Carrier or Provider	Amount Recovered

Tab 3 -- TPL Recovery (Drug Claims): MCO report required for claims that were recovered during the month due to third party insurance coverage for pharmacy services. Provide a total for columns “total amount paid” and “amount recovered”.

MCO Name **(MCO Number)**

Recovery Claims Data

For Month Ending _____

For Drug Claims

Medicaid Member ID	First Name	Last Name	Dispense Date	Drug Code	Product Description	Claim Paid Date	Paid to Provider NPI	Prescribing NPI	Drug Submit Charge	Total Amount Paid	Amount Recovered

Recovery Claims Cell Definitions

Recovery Claims Data					
Professional and UB Claims			Pharmacy Claims		
Cell Descriptor		**Definitions**	**Cell Descriptor**		**Definitions**
MCO Name		Name of the MCO submitting the report.	Medicaid Member ID		SCDHHS issued 10 digit Medicaid Identification Number for each beneficiary
MCO Number		Medicaid assigned legacy ID of the MCO submitting the report to SCDHHS.	First Name		Medicaid member first name that corresponds to the submitted Medicaid ID.
Medicaid Member ID		SCDHHS issued 10 digit Medicaid Identification Number for each beneficiary	Last Name		Medicaid member last name that corresponds to the submitted Medicaid ID.
First Name		Medicaid member first name that corresponds to the submitted Medicaid ID.	Dispense Date		Date the prescription was filled and picked up
Last Name		Medicaid member last name that corresponds to the submitted Medicaid ID.	NDC (Drug Code)		Universal product identifier for human drugs. The NDC number must be utilized for reporting purposes.
Beginning Date of Service		The providers first submitted date of service on the claim.	Product Description		The Drug Name that corresponds to the Drug code.
End Date of Service		The last date of service provided on the claim form.	Claim Paid/Processed Date		The date the MCO processed/paid the claim in question.
Claim Paid Date		The date the MCO paid/processed the claim in question.	Paid to Provider NPI		The National Provider Identifier of the individual or group that received payment for the claim in question.
Paid to Provider NPI		The National Provider Identifier of the individual or group that was reimbursed for the claim in question.	Prescribing NPI		The NPI of the prescribing provider.
Practice Specialty Description		The specialty of the provider where TPL related savings was realized. For example, oncology, radiology, laboratory, hospital	Drug Submit Charge		The total charge of the drug claim submitted by the provider that was cost avoided.
Line Submit Charge		The line charges that were submitted by the provider to the MCO.	Total Amount Paid		The total amount that was paid to the provider by the MCO for the pharmaceutical.
Line Amount Paid		The amount that was paid to the provider by the MCO on each line of the claim.	Drug Submit Charge		The charge amount submitted by the pharmacy provider.
Date Billed to Carrier or Provider		The date that the MCO billed the claim to the other insurer or the provider.	Amount Recovered		The total amount recovered by the MCO.
Amount Recovered		The total amount recovered by the MCO for each line item.			

5) **TPL Casualty Cases:** MCO report required for any casualty cases that the MCO is aware of during the month.
Tab 1 – Open Casualty Cases: Provide a total for columns “settlement amount” and “recovered amount”.

MCO NAME		MCO NUMBER										
FOR month ending_____												
OPEN CASUALTY CASES												
Medicaid Member ID#	**First Name**	**Last Name**	**Date of Injury**	**Primary Injury**	**Name of Liable Party**	**Lien Amt**	**Date Notice of Lien Letter Sent**	**Name of Atty/Insurance Co.**	**Case Status**	**Settlement Amt**	**Recovered Amt**	**Date Case Closed**

Tab 2 – Closed Casualty Cases: Provide a total for column “recovered amount if any”.

MCO NAME		MCO NUMBER									
FOR month ending_____											
CLOSED CASUALTY CASES											
Medicaid Member ID#	**First Name**	**Last Name**	**Reason for Close**	**Recovered Amt if any**	**Date Case Closed**						

Tab 3 – Casualty Case Alerts:

MCO NAME		MCO NUMBER										
FOR month ending_____												
CASE ALERTS												
# of Questionnares		**# of Atty Letters**		**# of Provider Letters**			**# of Insurance Letters**				**# Open/Clos**	

MCO Reporting Template Definitions		
OPEN CASUALTY CASES		
1.	**Medicaid Member Id:**	10 Digit Number used to identify the beneficiary
2.	**Date of Injury:**	Date the casualty incident occurred
3.	**Primary Injury:**	The chief medical complaint/damage caused by incident
4.	**Name of Liable Party:**	Name of person or entity who caused the injury to beneficiary
5.	**Lien Amount:**	The specific dollar amount paid on behalf of beneficiary for any and all accident related medical claims
6.	**Date of Notice Sent:**	Date the notice of the asserted lien was sent to liable party
7.	**Name of Atty/Insurance:**	Law Practice name, Attorney of record name or name of insurance company for the liable party
8.	**Case Status:**	Current update of case timeline after assertion of lien
9.	**Settlement Amount:**	The total amount agreed upon for injuries sustained in incident
10.	**Recovered Amount:**	Amount received in reimbursement to Medicaid for claims paid
11.	**Date Closed:**	Date the case is deemed inactive or resolved
12.	**Case Lead:**	Any documentation received in notification of a potential case
CLOSED CASUALTY CASES		
1.	**Reason for Close:**	The determination reached to consider a case inactive or resolved
Information Regarding Case Leads		
# of Questionnaires:		How many case leads by way of questionnaires received for the month?
# of Attorney Letters:		How many case leads by way of Attorney Letters received for the month?
# of Provider Letters:		How many case leads by way of Provider Letters received for the month?
# of Insurance Letters:		How many case leads by way of Insurance Letters received for the month?
# Open/Close:		Total number of case leads per category that resulted in an open case

Section 11.6: MCO Fraud and Abuse Monthly Report: Sample MCO report required for monthly fraud and abuse case reporting to program integrity. The report is a tool used by SCDHHS to coordinate investigations. It allows PI to see the MCO Provider/Recipient Cases. If an MCO investigator is working a complaint, once that complaint becomes a case, it will be reported on the monthly report. If at any time during an investigation FRAUD is suspected, complete a Fraud Referral Form and send to SCDHHS Program Integrity. The MCO will be contacted by Program Integrity in response to that form to coordinate case activity. Once Program Integrity accepts the referral, the MCO will be asked to suspend their investigation. This list is cumulative and data should not be deleted from this list.

INSTRUCTIONS
MCO MONTHLY / QUARTERLY FRAUD AND ABUSE ACTIVITIES REPORT

1. The format for the MCO Monthly Fraud and Abuse Activities Report is an Excel spreadsheet with three different worksheets. The first worksheet is for reporting the monthly fraud & abuse activities as specified; the second worksheet, titled "Look-Up Value," establishes the values for the information in the drop down boxes; the third worksheet, titled "Data Dictionary," defines the meaning of the column headings.

2. The monthly report is intended to be a full replacement file each month. This means the information is both cumulative and updated each month as new information becomes available.

3. The MCO should list all provider integrity or SIU cases or provider specific audits in the column for provider/recipient name, as indicated. "Program Integrity provider cases" means any provider under review by the MCO, including:

- Providers that are the subject of preliminary Investigations, including any investigations that are initiated through a REOMB response.
- Providers referred to SCDHHS on the Fraud and Abuse Referral Form.
- Audits Performed by the MCO; this would include Recovery Audit Contractor audits, pharmacy audits, etc.
- Providers identified through exception reports or fraud algorithms conducted by the MCO SIU.

This same column can be used to list any members who were referred to SCDHHS for suspected fraud. The column marked "Case Type" will show whether the entry refers to a Provider or a Recipient.

4. The format for the MCO Quarterly Fraud and Abuse report is also an Excel spreadsheet, and has worksheets for look-up values and data dictionary. The quarterly report, however, is intended to capture only the activities that occurred in that quarter. The first set of rows is summary data for the recoveries, cost avoidance and other fraud and abuse results for the quarter. The second set of rows should show the specific details, by provider, any results during the quarter. The first seven columns (A through G) should be copied from the monthly report for any provider case for

which the MCO had a recovery or administered a provide sanction during the quarter. The MCO should file a separate quarterly report each quarter – these reports are not cumulative.

5. Fill out the reports as completely as possible; use “NA” if no information exists for a particular column.

6. The monthly reports should be sent to SCDHHS via the secure portal. Requirements for submitting the monthly and quarterly reports will be in the MCO Policy and Procedure Guide. SCDHHS provides a secured Portal link via the Internet for the individual MCO s to use for sharing beneficiary/member and provider information in the context of fraud and abuse reviews and referrals. The Program Integrity site administrator will establish a password for the Plans to use to upload or download data through the secured portal. In order to receive the password for the link, each Plan must submit the appropriate contact information to Larry Overbaugh, the SCDHHS Site administrator, at OVERBAUG@scdhhs.gov

MCO Fraud and Abuse Report: Sample MCO report required for monthly fraud and abuse case reporting to program integrity. The report is a tool used by SCDHHS to coordinate investigations. It allows PI to see the MCO Provider/Recipient Cases. If an MCO investigator is working a complaint, once that complaint becomes a case, it will be reported on the monthly report. If at anytime during an investigation FRAUD is suspected, complete a Fraud Referral Form and send to SCDHHS Program Integrity. The MCO will be contacted by Program Integrity in response to that form to coordinate case activity. Once Program Integrity accepts the referral, the MCO will be asked to suspend their investigation. This list is cumulative and data should not be deleted from this list.

MCO SIU COMPREHENSIVE LIST OF REVIEWS AND FRAUD REFERRALS			
REPORT FREQUENCY: MONTHLY - FULL REPLACEMENT FILE	REPORT PREPARED BY:	EMAIL:	
DISTRIBUTION: SCDHHS MCO PI COORDINATOR	REPT SUBMISSION DT:	TELEPHONE #:	
*******USE CAPS FOR ALL DATA ENTRY FIELDS*********			

REC NO	MCO ID w NAME	CASE TYPE	MCO CASE NO	PROV/RECIP LAST NAME (and SUFFIX) IF GROUP, Group Name	FIRST NAME	MIDDLE NAME	NPI/MID	PROV MCO ID	NPI G/I	PROV TYPE	PROV CNTY	REASON FOR REVIEW	TYPE OF REVIEW	COMPLAINT/ALLEGATION	ALGORITHM NAME	TOTAL PAID DURING REVIEW PERIOD	ESTIMATED DOLLARS AT RISK	OVERPYMT AMT DETERMINED	OVERPAYMENT ADJUSTED FINAL AMT	AMT RECOVERED	REVIEW PERIOD BEGIN	REVIEW PERIOD END	CASE OPENED	CASE CLOSED	PYMT SUSP BEGIN	PYMT SUSP END	F&A IND	F&A BASIS	FIRST RPT DHHS	DT FRAUD REFERRAL FORM SENT TO	SCDHHS RESPONSE	DT MODIFIED	NOTES
1	HM9998 FIRST MCO	P	2001	DEAS, MICKEY, B, MD			1234567890	AC9999	I	20 PHYSICIAN	02 AIKEN	COMPLAINT FRM SCDHHS	OVER PYMT	PROVIDER DOES NOT INDICATE COB ON CLAIMS.	NONE		$150.00	$75.00			5/1/2013	5/2/2013	6/1/2013	6/30/2013			N	Z NOT FRAUD AND ABUSE	6/15/2013		NOT APPLICABLE	7/1/2013	
2	HM9998 FIRST MCO	P	2002	RADIOLOGY R US			1234567880	AC9998	G	06 MIDWIFE	07 BEAUFORT	EXCEPTION REPORT	FRAUD AND ABUSE	GROUP IS BILLING ALL PROCS WITH MOD 00	MODIFIER RPT A		$60,000.00	$0.00			4/1/2012	5/30/2013	6/2/2013		7/1/2013		Y	L REPEATED PATTERNS OF UP-CODING AND/OR UNBUNDLING - RESULTS IN LRG PROV OVERPYMT	7/2/2013		REFFERAL TO OAG	7/2/2013	

9/15/14 Changes:
1 - So that data can be converted to Share Point, removed "Prov/Recip Name (L, F, M, Suffix)" and added:
Prov/Recip Last Name (and Suffix) IF GROUP, Group Name
2 - First Name
3 - Middle Name
4 - "Reason for Review", Changed "Exception Report" to "Exception/Aberrant Report" and added " Referred to SIU Unit".
5 - "Type of Review", added "Prepay" and "Investigation Warranted" (meaning complaint warrants a full review).
6 - Added column "Total Paid During Review Period". See Data Dictionary.
7 - Added column "Overpayment Adjusted Final Amt". See Data Dictionary.
8 - Added column "Amt Recovered". See Data Dictionary.
9 - Column "First Rpt DHHS" will remain for currently populated data. See Data Dictionary.
10 - Added column "Dt Fraud Referral Form Sent to DHHS". See Data Dictionary.
11 - Column "DLU"has been renamed to "Dt Modified". See Data Dictionary.
12 - Added column "Notes".

MCO Fraud and Abuse Report Key: Key for completing the monthly fraud and abuse case reporting to program integrity.

CASE TYPE	LEN	Key: NPI G/ I	LEN	Key: Provider Type	LEN	Key: Reason for Review	LEN	Key: Type of Review	LEN	Key: Sanction1-4	LEN	Key: F&A Ind	Key: F&A Basis	LEN	Key: Prov County	LEN	SCDHHS RESPONSE	LEN	
P	1	G	1	00 NURSING HOME	15	EXCEPTION/ABERRANT REPORT	25	OVER PYMT	9	1 TERMINATION FOR CAUSE	23	Y	A NO DOCUMENTATION FOR SERVICES	31	00 OUT OF STATE	15	REFFERAL TO OAG	15	
R	1	I	1	01 INPATIENT HOSPITAL	21	COMPLAINT FRM SCDHHS	20	FRAUD AND ABUSE	15	2 SUSPENSION /WITHHOLD PAYMENT	30	N	B MANUFACTURED OR ALTERED DOCUMENTATION OR FORGED SIGNATURES	60	01 ABBEVILLE	12	ACCEPTED FOR SCDHHS ACTION	26	
				02 OUTPATIENT HOSPITAL	22	OTHER COMPLAINT	15	MEDICAL BILL AUDIT	18	3 REFER TO SCDHHS/INVESTIGATIONS	32		C UNAPPROVED MARKETING/RECRUITMENT OF PATIENTS	47	02 AIKEN	8	RETURNED TO MCO FOR ACTION	26	
				10 MENTAL HEALTH AND REHAB	26	BEOMB	5	PHARM AUDIT	11	4 RECOUPMENT	12		D USE OF ANOTHER PROVIDER'S ID BY AN EXCLUDED/TERMINATED INDIVIDUAL	67	03 ALLENDALE	12	REFERRAL TO OTHER AGENCY	24	
				19 OTHER MEDICAL PROFESSIONAL	30	PROV SELF DISCLOSURE	20	CREDIT BAL AUDIT	16	5 EDUCATIONAL	13		E BILLING FOR SVCS, SUPPL OR EQUIP NOT RENDERED OR USED FOR MEDICAID MEMBERS	76	04 ANDERSON	11	NOT APPLICABLE	14	
				20 PHYSICIAN	12	REFERRED TO SIU UNIT	20	INVESTIGATION WARRANTED	23	6 REFER TO LICENSING BOARD	26		F DUPLICATE AND/OR EXCESSIVE CLAIMS	35	05 BAMBERG	10			
				22 MEDICAL CLINICS (INC RCH /FQHC)	34	OTHER	5	PREPAY	6	7 REFER TO OTHER	16		G MATERIAL MISREPRESENTATION OF INFORMATION ON THE CLAIM	56	06 BARNWELL	11			
				30 DENTIST	10			OTHER	5	8 NONE	6		H BILLING AN UNREASONABLE OR IMPROBABLE # OF UNITS OR SERVICES (TIME BANDIT)	76	07 BEAUFORT	11			
				32 OPTICIAN	11								I BILLING UNREAS OR EXCESS AMT OF SUPPL OR SUPPL CLEARLY UNSUITABLE TO PAT NEEDS	80	08 BERKELEY	11			
				33 OPTOMETRIST	14								J PROCEDURE CODES/SERVICES DO NOT CORRESPOND W PROVIDER TYPE	60	09 CALHOUN	10			
				35 PODIATRIST	13								K PROCEDURE CODE/SERVICES/# OF UNITS NOT SUPPORTED BY MEMBER'S DIAGNOSIS	72	10 CHARLESTON	13			
				37 CHIROPRACTOR	15								L REPEATED PATTERNS OF UP-CODING AND/OR UNBUNDLING - RESULTS IN LRG PROV OVERPYM	81	11 CHEROKEE	11			
				60 HOME HEALTH/HOSPICE	22								M UNEXPLAINABLE, SIGNIFICANT SPIKES IN CLAIMS VOLUMES AND REIMBURSEMENT	71	12 CHESTER	10			
				61 CLTC	7								N BILLING FOR NUMEROUS DIAGNOSTICS WITH NO DOCUMENTATION FOR MEDICAL NECESSITY	78	13 CHESTERFIELD	15			
				70 PHARMACY	11								O TERMINATED FOR CAUSE	22	14 CLARENDON	12			
				76 DME	6								P CONFIRMED BEOMB COMPLAINT THAT SERVICES WERE NOT DELIVERED	60	15 COLLETON	11			
				80 LAB	6								Q OTHER	7	16 DARLINGTON	13			
				81 X-RAY	8								Z NOT FRAUD AND ABUSE	21	17 DILLON	9			
				82 PSYCHOLOGIST	15										18 DORCHESTER	13			
				99 OTHER	8										19 EDGEFIELD	12			
				04 AUDIOLOGIST	14										20 FAIRFIELD	12			
				06 MIDWIFE	10										21 FLORENCE	11			
				25 NURSE ANESTHETIST	20										22 GEORGETOWN	13			
				84 SPEECH THERAPIST	19										23 GREENVILLE	13			
				85 PHYSICAL THERAPIST	21										24 GREENWOOD	12			
				86 NURSE PRACTITIONER	21										25 HAMPTON	10			
				87 OCCUPATIONAL THERAPIST	25										26 HORRY	8			
				PC LICENSED PROFESSIONAL COUNSELOR	34										27 JASPER	9			
				SW LICENSED INDEPENDENT SOCIAL WORKER	37										28 KERSHAW	10			
															29 LANCASTER	12			
															30 LAURENS	10			
															31 LEE	6			
															32 LEXINGTON	12			
															33 MCCORMICK	12			
															34 MARION	9			
															35 MARLBORO	11			
															36 NEWBERRY	11			
															37 OCONEE	9			
															38 ORANGEBURG	13			
															39 PICKENS	10			
															40 RICHLAND	11			
															41 SALUDA	9			
															42 SPARTANBURG	14			
															43 SUMTER	9			
															44 UNION	8			
															45 WILLIAMSBURG	15			
															46 YORK	7			
															60 GA WITHIN SC SVC AREA	24			
															61 GA OUTSIDE SC SVC AREA	25			
															62 NC WITHIN SC SVC AREA	24			
															63 NC OUTSIDE SC SVC AREA	25			
															64 OTHER	8			

MCO Fraud and Abuse Data Dictionary: Data dictionary for completing the monthly fraud and abuse case reporting to program integrity.

Field Name	Qtry-Q; Mo-M Rpt	Field Description	Field Type	
RecNo	M,Q	Sequential Row Sequence Reference	integer	
MCO ID w Name	M,Q	SCDHHS Medicaid Assigned Number of the MCO and MCO Name (i.e., HM9998 First MCO)	char(30)	
Case Type	M/Q	Categorization of the Entry Record Designating Provider or Recipient	char(1)	Key: P-Provider; R-Recipient
MCO Case Number	M,Q	Unique Identifier assigned to the Review by the MCO i.e., MCO Case Number	integer	
Prov/Recip Last Name (and SUFFIX) IF GROUP, Group Name	M,Q	Name of Provider or Recipient (If Individual, Last Name) If GROUP, Group full name	char(60)	
First Name	M,Q	First Name of Provider or Recipient	char(18)	
Middle Name	M,Q	Middle Name of Provider or Recipient	char(18)	
NPI/MID	M,Q	Provider NPI or Medicaid ID Number of the Recipient	char(10)	
Prov MCO ID	M,Q	MCO Assigned Provider ID Number for the Provider	char(6)	
NPI G/I	M	Indicator describing the Reviewed Provider NPI -(G) Billing NPI or (I) or Servicing/Rendering NPI	char(1)	Key: (G) Billing; (I) Servicing/Rendering
Prov Type	M	SC Provider Type of the Reviewed Provider	char(37)	Key: See SCDHHS Provider Type Key
Prov Cnty	M	County of Reviewed Provider	char(27)	Key: See SCDHHS County Key
Reason for Review	M	Reason for Review	char(20)	Key: Exception Report; Complaint From SCDHHS; Other Complaint; BEOMB; Prov Self Disclosure; Identified by Fraud Finder Pro; Referred to SIU; Other
Type of Review	M	Type of Review	char(15)	Key: Over Pymt; Fraud and Abuse; Credit Bal Audit; Medical Bill Audit; Pharm Audit; Retro; Prepay; Other
Complaint/Allegation	M	Memo - Describe Reason for Review in Detail	Memo	
Algorithm Name	M	MCO Exception Report Name, if applicable	Memo	Input "NONE" When Not applicable
Total Paid During Review Period	M	Total Dollars Paid to Provider For Dates of Service During Review Period Dates	Currency	
Estimated Dollars at Risk	M	Of the "Total Paid During Review Period", the Total Estimated Dollars at Risk Identified by MCO	Currency	
Overpayment Amt Determined	M	Total Overpayment or Underpayment Identified by MCO (Cummulative to date)	Currency	
Overpayment Adjusted Final Amt	M	Total Overpayment or Underpayment Identified by MCO (Minus Adjustments)	Currency	
Amt Recovered	M	Total Amount Recovered by MCO at time of Monthly Report (Figure can change Monthly Depending on Payment Terms)	Currency	
Review Period Begin	M	Beginning Date of Service in Review Period	Date	
Review Period End	M	Ending Date of Service in Review Period	Date	
Case Opened	M	Date Review Began	Date	
Case Closed	M	Date Review Closed	Date	
Sanction1*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Sanction2*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Sanction3*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Sanction4*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Pymt Susp Begin	M	MCO Payment Suspension Begin Date	Date	
Pymt Susp End	M	MCO Payment Suspension End Date	Date	
F&A Ind	M	Report of Fraud and Abuse Referral Made to SCDHHS Indicator; If 'YES', SCDHHS should have F&A Referral Form from MCO on file. If 'NO' - Review does not involve a F&A Referral.	char(1)	Key: Y-Yes; N-No Should also be on Form
F&A Basis	M	Basis for Provider Referral (Same info as on F&A Referral Form)	char(81)	Key: A NO DOCUMENTATION FOR SERVICES; B MANUFACTURED OR ALTERED DOCUMENTATION OR FORGED SIGNATURES; C UNAPPROVED MARKETING/RECRUITMENT OF PATIENTS; D USE OF ANOTHER PROVIDER'S ID BY AN EXCLUDED/TERMINATED INDIVIDUAL; E BILLING FOR SVCS, SUPPL OR EQUIP NOT RENDERED OR USED FOR MEDICAID MEMBERS; F DUPLICATE AND/OR EXCESSIVE CLAIMS; G MATERIAL MISREPRESENTATION OF INFORMATION ON THE CLAIM; H BILLING AN UNREASONABLE OR IMPROBABLE # OF UNITS OR SERVICES (TIME BANDIT); I BILLING UNREAS OR EXCESS AMT OF SUPPL OR SUPPL CLEARLY UNSUITABLE TO PAT NEEDS; J PROCEDURE CODES/SERVICES DO NOT CORRESPOND W PROVIDER TYPE; K PROCEDURE CODE/SERVICES/# OF UNITS NOT SUPPORTED BY MEMBER'S DIAGNOSIS; L REPEATED PATTERNS OF UP-CODING AND/OR UNBUNDLING - RESULTS IN LRG PROV OVERPYMT; M UNEXPLAINABLE, SIGNIFICANT SPIKES IN CLAIMS VOLUMES AND REIMBURSEMENT; N BILLING FOR NUMEROUS DIAGNOSTICS WITH NO DOCUMENTATION FOR MEDICAL NECESSITY; O TERMINATED FOR CAUSE; P CONFIRMED BEOMB COMPLAINT THAT SERVICES WERE NOT DELIVERED; Q OTHER; Z NOT FRAUD AND ABUSE;
First Rpt SCDHHS	M	Date MCO First Reported to SCDHHS on the Monthly Report	Date	
Dt Fraud Referral Form Sent to DHHS	M	Date MCO Sent Fraud Referral Form to SCDHHS PI	Date	
SCDHHS Response	M	Return Response from SCDHHS	char(26)	Key: Referral to OAG; Accepted for SCDHHS Action; Returned to MCO for Action; Referral to Other Agency; Not Applicable
~~DLU~~ Dt Modified	M	Date Case Record Row Data Was Last Updated by MCO	Date	
Overpayment Amt Collected	Q	Amount of Overpayments Collected	Currency	
Notes	M	Additional comments	Memo	
YR/QTR Ending (yyyy_qtr)	Q	Year and Quarter reported on	char(6)	
Recoveries from Cases	Q	Total of All Recoveries from All PI Related Cases	Currency	
Total Cost Avoidance	Q	Total Dollar Cost Avoided Due to PI Related Activities. (Cost Avoid is Determined by MCO Standards).	Currency	
All Other Recoveries	Q	Total Dollar from All Other PI Related Recoveries (ex. RAC and pharmacy audits)	Currency	
Total # Providers TFC	Q	Total Number of Providers Reported During the Quarter as Terminated For Cause	integer	
Total # Providers Denied Credentialing	Q	Total Number of Providers Reported During the Quarter as Denied Credentialing	integer	
***All information should be input as soon as the information becomes known.				
***The following fields may or may not be input depending on the type of review and review outcome. It is expected that all other fields should have an entry most of the time.				
Algorithm Name				
Total Paid During Review Period				
Estimated Dollars at Risk				
Overpayment Amt Determined				
Overpayment Adjusted Final Amt				
Amt Recovered				
Overpayment Amt Collected				
Case Closed				
Sanction1-4*				
Pymt Susp Begin				
Pymt Susp End				
*List SANCTIONS 1-4 in Order of Sanction Severity; 1-Highest Severity to 4-Lowest Severity				

MCO Provider Termination Report: Sample MCO report required for monthly provider termination case reporting to program integrity.

	SC Department of Health and Human Services (SCDHHS) * Reporting Unit - MCCS, MCO, NEMT Broker											
	(A) MCO Reporting:						MCCS/NEMT:					
	(B) MONTHLY REPORTING PERIOD:											
	MONTH:		YEAR:									
(C)	(D)			(E)		(F)	(G)	(H)		(I)	(J)	(K)
Rec No	PROVIDER GROUP NAME OR INDIV PROV LAST NAME	INDIV PROV FIRST NAME	INDIV PROV MI	SSN	FEIN	NPI	TAX ID NAME	PHYSICAL LOCATION ADDRESS	CITY, STATE, ZIP + 4	TERMINATION REASON	DENIAL REASON	TERMINATION or DENIAL DATE
1												
2												
3												
4												
5												

MCO Provider Termination Report Values: The lookup values for the MCO provider termination report.

KEY	SPREADSHEET FIELD	TERMINATION CODE	TERMINATION REASON CODES	DENIAL CODE	DENIAL REASON CODES
(A)	Name of MCO Reporting (Dropdown Values)	**T1**	Person with 5% or greater ownership & has been convicted of a crime related to Medicare/Medicaid or title XXI in past 10 years	**D1**	Person with 5% or greater ownership & has been convicted of a crime related to Medicare/Medicaid or title XXI in past 10 years
	Absolute Total Care HM2200	**T2**	Provider terminated on or after January 1, 2011 by Medicare or another states' Medicaid or CHIP program	**D2**	Provider terminated on or after January 1, 2011 by Medicare or another states' Medicaid or CHIP program
	Advicare HM3400	**T3**	Provider/person with an ownership or control interest or who is an agent or managing employee of the provider fail to submit timely accurate information	**D3**	Provider/person with an ownership or control interest or who is an agent or managing employee of the provider fail to submit timely accurate information
	Blue Choice HM3200	**T4**	Provider fails to permit access to provider's location for site visits	**D4**	Provider or person with 5% or greater direct or indirect ownership interest fails to submit fingerprints within 30 days
	Molina HM3600	**T5**	Provider has falsified information provided on application	**D5**	Provider fails to permit access to provider's location for site visits
	Select Health HM1000	**T6**	Cannot verify the identity of the provider	**D6**	Provider has falsified information provided on application
	Well Care HM3800	**T7**	Provider fails to comply with the terms of the enrollment agreement	**D7**	Cannot verify the identity of the provider
(B)	Enter Reporting Month (MO/CCYY) (Dropdown Values)	**T8**	Provider has contract with SCDHHS and has either failed to produce required deliverables or not in compliance with contract and contract terminated	**D8**	Provider's license is inactive/suspended/revoked
(C)	Enter Record Number	**T9**	Provider has not repaid an outstanding debit or recoupment identified through a Program Integrity review	**D9**	Provider fails to meet credentialing, certification and/or additional licensure requirements as specified by DHHS
(D)	Enter EITHER Provider Group Name if reporting a group OR Individual Name if reporting an individual (Last, First, MI)	**T10**	Provider's license is inactive/suspended/revoked	**D10**	Provider fails to sign/or send in contract within required time limits
(E)	Enter SSN of individual or FEIN of Group/Organization	**T11**	Provider has been terminated by a Managed Care Organization for reasons due to Fraud or Quality of Care		
(F)	Enter NPI (if applicable)				
(G)	Enter Tax ID Name				
(H)	Enter Physical Location Address, City, State, Zip + 4				
(I)	Enter Termination Reason				
(J)	Enter Denial Reason				
(K)	Enter Termination Date (MO/Day/Year)				
	MONTH				
	JAN				
	FEB				
	MAR				
	APR				
	MAY				
	JUN				
	JUL				
	AUG				
	SEP				
	OCT				
	NOV				
	DEC				
	YEAR				
	2012				
	2013				
	2014				
	2015				
	2016				

Table 13.1: Claims Payment Accuracy Report: This report is to be submitted to the MCO's monthly SharePoint library. The report details claims outcomes for the MCO's on a monthly basis.

Claims Payment Report		
Number of Enrollees		
Claims Volume	**Number**	
1. Beginning Claims Inventory		
2. Number of Claims Received (Reporting Month)		
3. Total Number of Claims Available for Processing		
4. Number of Paid Claims	**Number**	**Dollar Amount**
Professional (837P)		
Institutional (837I)		
Pharmacy (NCPDP)		
6. Number of Denied Claims		
6a. Number of Clean Denied Claims		
6b. Number of Unclean Denied Claims		
7. Total Claims Processed		
8. Total Claims Unprocessed		
Clean Claims Processing Time	**Number**	**Percentage**
9. Number of Claims Processed Within 30 Days		
10. Number of Claims Processed 31-90 Days		
11. Number of Claims Processed 91-365 Days		
12. Number of Claims Processed over 365 Days		
Claims Line Summary	**Number**	**Dollar Amount**
13a. Number of Denied Claim Lines (Administrative)		
13b. Number of Denied Claim Lines (Clinical)		
13c. Number of Paid Claim Lines		
14. Total Claim Lines		
Claims Payment Statistics		
15. Average Paid Time (Stamped Received Date to Paid Date)		
Denial Claim Reasons	**Number**	**Percentage**
The National Drug Code (NDC), NDC Unit of Measure and/or NDC quantity billed cannot be accepted. One or more of the fields is missing, incomplete, invalid, or deactivated.		
This is a duplicate claim.		
The patient was not an eligible member at the time services were rendered.		
Benefits are not provided for services obtained from non-participating providers.		
Claim submitted has been divided into more than one claim record for benefit.		
An adjustment will be made to original submission.		

Section 14.5: Encounter Submission Summary: Report summarizing monthly claims paid, accepted encounters, rejected encounters, and completeness percentage.

File naming convention will be as follows:

Example: "Encounter Submission Summary_2016DP02R03"
Explanation: Report Name followed by Calendar Year then Data Period Month then Reporting Month (ex. February 2016 Data Period will be Reported with the other March data due for submission April 15th).

Monthly Encounters Submitted by MCO

MCO Name:

For Calendar Year _____

Submission Date:

	MCO Paid Claims - Per MCO Claims System (Report claims paid in month indicated)						MMIS Accepted Encounters * (including non-critical errors) (Report Accepted Encounters Submitted by 25th of Month Following Paid Month)						MMIS Rejected Encounters ** (critical errors only) (Report Rejected Encounters Submitted by 25th of Month Following Paid Month)						Completeness Percentage (auto calculated) (Accepted Encounter Amount/Claim Paid Amount)		
	837P		837I		NCPDP		837P		837I		NCPDP		837P		837I		NCPDP		837 P	837 I	NCPDP
MCO Paid Month	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Record Count	Total Paid Amt	Amount Paid	Amount Paid	Amount Paid
January																			NR	NR	NR
February																			NR	NR	NR
March																			NR	NR	NR
April																			NR	NR	NR
May																			NR	NR	NR
June																			NR	NR	NR
July																			NR	NR	NR
August																			NR	NR	NR
September																			NR	NR	NR
October																			NR	NR	NR
November																			NR	NR	NR
December																			NR	NR	NR

* Encounters to be reported include ONLY those **ACCEPTED** by MMIS in Paid Month or by 25th day of Month after Payment.
DO NOT adjust previously submitted claim or encounter data to reflect submissions in subsequent months

** Encounters to be reported include ONLY those **REJECTED** by MMIS in Paid Month or by 25th day of Month after Payment

*** Summary Explanation required if Completeness Percentage is LESS than 97%
Submit explanation by Encounter Type (Professional; Institutional - Inpatient; Institutional - Outpatient; NCPDP)

Encounter Submission Summary Definitions

Value	Definition
837P	Professional claims and encounters submitted in the 837P EDI format
837I	Institutional claims and encounters submitted in the 837I EDI format
NCPDP	Pharmacy claims and encounters submitted in the NCPDP format
MCO Paid Claims	***Record Count*** *:* The number of MCO Claims with a paid date in the month indicated on the row. Example: Acme MCO paid 100 837 P professional records during the month of January.
	Total Paid Amount: The dollar amount of MCO Claims with a paid date in the month indicated on the row. Example: Acme MCO had a total paid amount of $1,000 837 P professional records accepted during the month of January.
MMIS Accepted Encounters	***Record Count:*** The number of encounters accepted into the Medicaid system during the month on the row; including those accepted with non-critical errors. Example: Acme MCO had 100 837 P professional records accepted into the Medicaid system during the month of January.
	Total Accepted Amount: The total paid amount for all encounters accepted into the Medicaid system during the month on the row. Example: Acme MCO had $1,000 in 837 P professional encounters accepted during the month of January.
MMIS Rejected Encounters	***Rejected Record Count:*** The number of encounters rejected by the Medicaid system for the paid month indicated on the row. Example: Acme MCO had 100 837 P rejected records that were paid during the month of January.
	Total Paid Amount: The total dollar amount of records rejected by the Medicaid system for the paid month indicated on the row. Example: Acme MCO had a total of $1,000 837 encounters rejected that were paid during the month of January.

REPORT REQUIREMENTS

QUARTERLY

Managed Care Report Name	Format	Report Timing
Quarterly Reporting Requirements		
Section 7		
Section 7.3.1.1		
Centering Program	Centering report template provided to MCO's along with reimbursement for centering services provided during a quarter that was found in previous quarters encounter data	Quarterly
MCO Withhold	Report template shared with the MCO to indicate quarterly withholding done to MCO's	Quarterly
Section 7.4.3.2		
FQHC RHC Wrap Payments Qtr	Current FQHC/RHC reports required for wrap payment process.	Quarterly
Section 9		
Section 9.1.3.2		
Member Grievance Summary	Grievance Summary reporting required of the MCO.	Quarterly
Member Appeal Log	Appeal reporting required of the MCO.	Quarterly
Section 9.2.16		
Provider Dispute Log	Provider dispute reporting required of the MCO.	Quarterly
Section 11		
Section 11.6		
Quarterly MCO Fraud and Abuse	Quarterly reporting of fraud and abuse. This report should be submitted directly to Program Integrity's SharePoint site.	Quarterly
Section 13		
Table 13.1.1		
GME	Report detailing payment for Graduate Medical Education Providers and Institutions	Quarterly
Section 14		
Section 14.8		
FQHC RHC Wrap Payments Qtr	See section 7.4.3.2 Above	Quarterly
Section 14.10.8		
CRCS	Capitation Rate Calculation Sheet. Report detailing the units and amount paid per rate category.	Quarterly

Section 7.3.1.1: Centering Report: This report format is utilized for indicating those encounters that SCDHHS is making a supplemental payment for centering related services at the end of each quarter.

Centering Incentive Payment for								
Managed Care Plan	Claim Control Number	Medicaid Number	Service Date	Procedure Code	Plan Paid Amount	Units	Patients	Incentive Payment

Section 7.3.1.1: MCO Withhold Report: This report format is utilized for indicating withholds that SCDHHS initiates at the end of a reporting quarter as a component of its quality program.

South Carolina
Department of Health and Human Services
Withhold Calculation

MCO Name
Member Months

Rate Category		Month 1	Month 2	Month 3	Total	Rate w/o STP	Risk Adj	Withhold Rate	Withhold Total
0-2 months old	AH3							0.00	0.00
3-12 months old	AI3							0.00	0.00
1-6 M&F	AB3							0.00	0.00
7-13 M&F	AC3							0.00	0.00
14-18 M	AD1							0.00	0.00
14-18 F	AD2							0.00	0.00
19-44 M	AE1							0.00	0.00
19-44 F	AE2							0.00	0.00
45+ M&F	AF3							0.00	0.00
Foster Care any age M&F	FG3							0.00	0.00
Maternity Kicker any age	NG2							0.00	0.00
SSI w/o Medicare (0-18)	SO3							0.00	0.00
SSI w/o Medicare (19-up)	SP3							0.00	0.00
OCWI F	WG2							0.00	0.00
		0	0	0	0				0.00
Total Withhold									0.00

Section 7.4.3.2: FQHC/RHC Wrap Payments

Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft Excel workbook. A participation list shall be provided in a separate file. General instructions can be obtained by contacting the appropriate staff member in Ancillary Reimbursements.

FQHC/RHC Encounter Data-Detail

Field	Data Element Name	Example Length/Field Type	Field Description
1	Unique Claim Number	ABC999999999999 (Text-15)	Unique number assigned by the MCO to identify the entire claim record.
2	Legacy Number	RHC000 or FQC000 (Text-6)	A 6-digit Number assigned by the Medicaid Program Office to uniquely identify the practice/facility as an RHC or FQHC.
3	NPI Number	9999999999 (Number-10)	The National Provider Identification number assigned to the FQHC or RHC.
4	Name	ABC Health Care (Text-50)	FQHC or RHC Provider legal name.
5	Tax ID	99-9999999 (Text-10)	The federal tax identification number assigned to the FQHC or RHC.
6	Member Last Name	Smith (Text-20)	The member's last name.
7	Member First Name	John (Text-20)	The member's first name.
8	Medicaid ID	99999999999 (Number-10)	The 10-digit Medicaid number assigned to the member.
9	Member Plan Type	9 (Number-1)	Indicate whether the record is: 1-Fee-for-Service; or 2-CAP Encounter.
10	Date of Service	00/00/0000 (Date-10)	Date of service.
11	CPT Code	99999 (Text-5)	CPT Code.
12	CPT Code Modifier	99 (Text-2)	2-digit modifier for CPT Code.

FQHC/RHC Encounter Data-Detail Cont.

Field	Data Element Name	Example Length/Field Type	Field Description
13	Net Paid Amount	$9,999.99 (Currency-6)	MCO amount paid for service rendered.
14	Other Insurance Amount	$9,999.99 (Currency-6)	Other insurance amount paid for this service (i.e., Third Party Liability).
15	Co-Pay Indicator	$9.99 (Currency-3) or C (Text 1)	Co-Pay Paid Amount or Co-Pay Indicator
16	Claim Type	E (Text-1)	Indicate whether the CPT code is: E-Evaluation & Management; M-Medicine; or S-Surgery.
17	Status	P (Text-1)	Indicate whether the record is: P-Paid or D-Denied.
18	Claim Explanation 1	Duplicate Encounter (Text-50)	If the claim was not paid the contracted rate for any reason, provide an explanation (primary). Explanation to be provided may include one of the following: Authorization or referral not obtained; Missing CPT code or other critical information; Diagnosis invalid or missing; individual provider ID must be submitted; member not enrolled on date of service; duplicate encounter; or this procedure is considered redundant to the primary procedure. Other explanations may be used if not included on this list.
19	Claim Explanation 2	(Text-50)	If the claim was not paid the contracted rate for any reason, provide an explanation (secondary). See description for Field 16.
20	Attending Physician Name	Doolittle, William (Text-30)	The attending physician's legal name.
21	Attending Physician Number	999999 (Text-6)	The Medicaid number assigned to the attending physician.
22	MCO Name	ABC MCO (Text-20)	MCO name.
23	MCO Provider Number	HM9999 (Text-6)	MCO provider number assigned by the Medicaid Program Office.

ATTACHMENT 2

ENCOUNTER /CLAIMS DETAIL DATA FILE - ACTUAL LAYOUT

Attachment 2 is the actual horizontal file format of the 22 Data Fields provided in Attachment 1.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Unique Claim Number	Legacy Number	NPI Number	Name	Tax ID	Member Last Name	Member First Name	Medicaid ID	Member Plan Type	Date of Service	CPT Code	Mod	Paid Amount	Other Ins. Amount	Co-Pay Indicator	Claim Type	Status	Claim Explanation 1	Claim Explanation 2	Attending Physician Name	Attending Physician Number	MCO Name	MCO Number
ABC999999999999	RHC999	9999999999	ABC Health Care	99-9999999	Smith	John	99999999999	2	00/00/0000	99213	0	$9,999.99	$9,999.99	9.99/C	E	P	Duplicate Encounter		Doolittle, William	999999	ABC MCO	HM9999

Section 9.1.3.2: Member Grievance Summary: The MCO should submit this summary data compiling it monthly and then submitting to SCDHHS on a quarterly basis**.** When reporting, replace the Month headings below with the specific reporting period.

SUMMARY GRIEVANCE REPORT
MCO Name:

		Volume per Month			Percentage of Total Membership per Month		
Category	Proposed Definition for Grievance	Month 1	Month 2	Month 3	Month1	Month2	Month 3
Billing	Any grievance related to a member being billed or having to pay for a service. However, if the member is indicating that they cannot access providers and/or services they currently need due to the billing issue, then the difficulty accessing care category should be utilized.						
Difficulty Accessing Care	Any grievance related to members ability to access care from needed providers. This would include lack of participating providers, and an inability obtaining referrals and prior authorization to additional providers.						
Member Eligibility	Any grievance regarding membership eligibility and verification issues related to membership on a month in question.						
ID Card Issue	This would include not receiving ID cards. Any problems with the cards including errors identified on the issued card.						
MCO Administrative Grievance	This category includes grievances regarding the plans beneficiary call centers, case management issues with the plan, the plans policies or procedures, nurse help lines, and any additional benefits the plan offers.						
Medical Treatment Grievance	Any grievance related to a member's dissatisfaction with the medical care provided or perceived as not provided or perceived as inappropriate care. However, if the member is indicating that they cannot access providers and/or services they currently need due to the treatment issue, then this would be classified as difficulty accessing care.						
Provider Office and Staff Grievance	Any grievance related to a member's dissatisfaction with a provider that is not related to the medical care. This would include a lack of a caring attitude, rude staff, office staff not responsive, etc. However, if the member is indicating that they cannot access providers and/or services they currently need due to the dissatisfaction, then this becomes an access grievance.						
Other Issues	Any other issues not fitting in the categories referenced above.						

Section 9.1.3.2: Member Appeal Log
Collected Monthly, Reported Quarterly

For each appeal, utilize the following to report information:

Date Filed: Enter the exact month, day and year the appeal was received by the MCO.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the MCO by SCDHHS.

Summary of Appeal: Give a brief description of the member's appeal. Include enough information to provide SCDHHS with an understanding of the member's appeal.

Resolution/Response Given: Indicate whether the appeal is pending or closed at the time of reporting. Indicate the resolution, the response given to the member, include enough information to provide SCDHHS with an understanding of how the appeal was resolved. If the grievance is pharmaceutical in nature, please provide the name of the medication and the date the prescription was filled by the member.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the appeal.

Date of Resolution: The date the resolution was achieved. Should be reported at the time resolution of the appeal is achieved.

Case Number: The MCO assigned case number.

QUARTERLY MEMBER APPEAL LOG

MCO Name:

Date Filed	Member Name	Member Number	Summary of Appeal	Resolution / Response Given	Resulting Corrective Action	Resolution Date	Case Number

Section 9.2.16: Provider Dispute Log: The MCO should submit this summary data compiling it monthly and then submitting to SCDHHS on a quarterly basis**.**

Provider Dispute Log with Summary Information
Collected Monthly, Reported Quarterly

For each appeal, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the dispute was received by the MCO.

Provider Name and Number: Indicate the provider's name and provider's NPI number.

Summary of Dispute: Give a brief description of the dispute. Include enough information to provide SCDHHS with an understanding of the provider dispute.

Current Status: Indicate the current status of the appeal at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc.

Resolution/Response Given: Indicate the resolution, the response given to the provider, include enough information to provide SCDHHS with an understanding of how the dispute was adjudicated.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the dispute.

Date of Resolution: The date the resolution was achieved. Should be reported at the time resolution was adjudicated.

QUARTERLY PROVIDER DISPUTE LOG (Indicate Qtr/Yr Filing for)

MCO Name:

Date Filed	Provider Name	Provider Number (NPI)	Summary of Dispute	Resolution / Response Given	Resulting Corrective Action	Resolution Date	Case Number

Section 11.6: Quarterly MCO Fraud and Abuse Report: Sample MCO report required for quarterly fraud and abuse case reporting to program integrity. This report is used to summarize activities for the quarter. The "Recoveries from Cases" should total the cases in the lower section for the specific quarter. The "Total Cost Avoidance" is calculated by the MCO and reported for the specific quarter.

INSTRUCTIONS
MCO MONTHLY / QUARTERLY FRAUD AND ABUSE ACTIVITIES REPORT

1. The format for the MCO Monthly Fraud and Abuse Activities Report is an Excel spreadsheet with three different worksheets. The first worksheet is for reporting the monthly fraud & abuse activities as specified; the second worksheet, titled "Look-Up Value," establishes the values for the information in the drop down boxes; the third worksheet, titled "Data Dictionary," defines the meaning of the column headings.

2. The monthly report is intended to be a full replacement file each month. This means the information is both cumulative and updated each month as new information becomes available.

3. The MCO should list all provider integrity or SIU cases or provider specific audits in the column for provider/recipient name, as indicated. "Program Integrity provider cases" means any provider under review by the MCO, including:

- Providers that are the subject of preliminary Investigations, including any investigations that are initiated through a REOMB response.
- Providers referred to SCDHHS on the Fraud and Abuse Referral Form.
- Audits Performed by the MCO; this would include Recovery Audit Contractor audits, pharmacy audits, etc.
- Providers identified through exception reports or fraud algorithms conducted by the MCO SIU.

This same column can be used to list any members who were referred to SCDHHS for suspected fraud. The column marked "Case Type" will show whether the entry refers to a Provider or a Recipient.

4. The format for the MCO Quarterly Fraud and Abuse report is also an Excel spreadsheet, and has worksheets for look-up values and data dictionary. The quarterly report, however, is intended to capture only the activities that occurred in that quarter. The first set of rows is summary data for the recoveries, cost avoidance and other fraud and abuse results for the quarter. The second set of rows should show the specific details, by provider, any results during the quarter. The first seven columns (A through G) should be copied from the monthly report for any provider case for which the MCO had a recovery or administered a provide sanction during the quarter. The MCO should file a separate quarterly report each quarter – these reports are not cumulative.

5. Fill out the reports as completely as possible; use “NA” if no information exists for a particular column.

6. Monthly and Quarterly Fraud and Abuse reports should be submitted directly to Program Integrity via the PI SharePoint site.

MCO SIU QUARTERLY REPORT									REPORT PREPARED BY:			EMAIL:	
DISTRIBUTION: SCDHHS MCO PI COORDINATOR									REPT SUBMISSION DT:			TELEPHONE #:	
********USE CAPS FOR ALL DATA ENTRY FIELDS*********													
YR / QTR ENDING (yyyy_qtr)	RECOVERIES FROM CASES		TOTAL COST AVOIDANCE				ALL OTHER RECOVERIES		TOTAL # PROVIDERS TFC		TOTAL # PROVIDERS DENIED CREDENTIALING		
2013_4													
REC NO	MCO ID w NAME	CASE TYPE	MCO CASE NO	PROV/RECIP LAST NAME (and SUFFIX) IF GROUP, Group Name	FIRST NAME	MIDDLE NAME	NPI/MID	PROV MCO ID	OVERPAYMENT AMT COLLECTED	SANCTION1	SANCTION2	SANCTION3	SANCTION4
1	HM9998 FIRST MCO	P	2001	DEAS, MICKEY, B, MD			1234567890	AC9999	$50.00	1 TERMINATION FOR CAUSE	2 SUSPENSION /WITHHOLD PAYMENT	3 REFER TO SCDHHS/INVESTIGATIONS	4 RECOUPMENT

9/15/14 Changes:
1 - So that data can be converted to Share Point, removed "Prov/Recip Name (L, F, M, Suffix) and added:
Prov/Recip Last Name (and Suffix) IF GROUP, Group Name
2 - First Name
3 - Middle Name

MCO Fraud and Abuse Report Key: Key for completing the quarterly fraud and abuse case reporting to program integrity.

CASE TYPE	LEN	Key: Sanction1-4	LEN		
P	1	1 TERMINATION FOR CAUSE	23		
R	1	2 SUSPENSION /WITHHOLD PAYMENT	30		
		3 REFER TO SCDHHS/INVESTIGATIONS	32		
		4 RECOUPMENT	12		
		5 EDUCATIONAL	13		
		6 REFER TO LICENSING BOARD	26		
		7 REFER TO OTHER	16		
		8 NONE	6		

MCO Fraud and Abuse Report Key: Key for completing the quarterly fraud and abuse case reporting to program integrity.

MCO Fraud and Abuse Data Dictionary: Key for completing the quarterly fraud and abuse case reporting to program integrity.

Field Name	Qtry-Q; Mo-M Rpt	Field Description	Field Type	
RecNo	M,Q	Sequential Row Sequence Reference	integer	
MCO ID w Name	M,Q	SCDHHS Medicaid Assigned Number of the MCO and MCO Name (i.e., HM9998 First MCO)	char(30)	
Case Type	M/Q	Categorization of the Entry Record Designating Provider or Recipient	char(1)	Key: P-Provider; R-Recipient
MCO Case Number	M,Q	Unique Identifier assigned to the Review by the MCO i.e., MCO Case Number	integer	
Prov/Recip Last Name (and SUFFIX) IF GROUP, Group Name	M,Q	Name of Provider or Recipient (If Individual, Last Name) If GROUP, Group full name	char(30)	
First Name	M,Q	First Name of Provider or Recipient	char(30)	
Middle Name	M,Q	Middle Name of Provider or Recipient	char(30)	
NPI/MID	M,Q	Provider NPI or Medicaid ID Number of the Recipient	char(10)	
Prov MCO ID	M,Q	MCO Assigned Provider ID Number for the Provider	char(6)	
NPI G/I	M	Indicator describing the Reviewed Provider NPI -(G) Billing NPI or (I) or Servicing/Rendering NPI	char(1)	Key: (G) Billing; (I) Servicing/Rendering
Prov Type	M	SC Provider Type of the Reviewed Provider	char(37)	Key: See SCDHHS Provider Type Key
Prov Cnty	M	County of Reviewed Provider	char(27)	Key: See SCDHHS County Key
Reason for Review	M	Reason for Review	char(20)	Key: Exception Report; Complaint From SCDHHS; Other Complaint; BEOMB; Prov Self Disclosure; Identified by Fraud Finder Pro; Referred to SIU; Other
Type of Review	M	Type of Review	char(15)	Key: Over Pymt; Fraud and Abuse; Credit Bal Audit; Medical Bill Audit; Pharm Audit; Retro; Prepay; Other
Complaint/Allegation	M	Memo - Describe Reason for Review in Detail	Memo	
Algorithm Name	M	MCO Exception Report Name, if applicable	Memo	Input "NONE" When Not applicable
Total Paid During Review Period	M	Total Dollars Paid to Provider For Dates of Service During Review Period Dates	Currency	
Estimated Dollars at Risk	M	Of the "Total Paid During Review Period", the Total Estimated Dollars at Risk Identified by MCO	Currency	
Overpayment Amt Determined	M	Total Overpayment or Underpayment Identified by MCO (Cummulative to date)	Currency	
Overpayment Adjusted Final Amt	M	Total Overpayment or Underpayment Identified by MCO (Minus Adjustments) (Underpayment represented by (-))	Currency	
Amt Recovered	M	Total Amount Recovered by MCO at time of Monthly Report (Figure can change Monthly Depending on Payment Terms)	Currency	
Review Period Begin	M	Beginning Date of Service in Review Period	Date	
Review Period End	M	Ending Date of Service in Review Period	Date	
Case Opened	M	Date Review Began	Date	
Case Closed	M	Date Review Closed	Date	
Sanction1*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Sanction2*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Sanction3*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Sanction4*	Q	MCO Action taken as as a result of review (List up to 4 possible sanctions in order of severity)	char(30)	Key: 1 Termination for Cause; 2 Suspension/Withhold Payment; 3 Refer to SCDHHS/Investigations; 4 Recoupment; 5 Educational; 6 Refer to Licensing Board; 7 Refer to Other; 8 None
Pymt Susp Begin	M	MCO Payment Suspension Begin Date	Date	
Pymt Susp End	M	MCO Payment Suspension End Date	Date	
F&A Ind	M	Report of Fraud and Abuse Referral Made to SCDHHS Indicator; If 'YES', SCDHHS should have F&A Referral Form from MCO on file. If 'NO' - Review does not involve a F&A Referral.	char(1)	Key: Y-Yes; N-No Should also be on Form
F&A Basis	M	Basis for Provider Referral (Same info as on F&A Referral Form)	char(81)	Key: A NO DOCUMENTATION FOR SERVICES; B MANUFACTURED OR ALTERED DOCUMENTATION OR FORGED SIGNATURES; C UNAPPROVED MARKETING/RECRUITMENT OF PATIENTS; D USE OF ANOTHER PROVIDER'S ID BY AN EXCLUDED/TERMINATED INDIVIDUAL; E BILLING FOR SVCS, SUPPL OR EQUIP NOT RENDERED OR USED FOR MEDICAID MEMBERS; F DUPLICATE AND/OR EXCESSIVE CLAIMS; G MATERIAL MISREPRESENTATION OF INFORMATION ON THE CLAIM; H BILLING AN UNREASONABLE OR IMPROBABLE # OF UNITS OR SERVICES (TIME BANDIT); I BILLING UNREAS OR EXCESS AMT OF SUPPL OR SUPPL CLEARLY UNSUITABLE TO PAT NEEDS; J PROCEDURE CODES/SERVICES DO NOT CORRESPOND W PROVIDER TYPE; K PROCEDURE CODE/SERVICES/# OF UNITS NOT SUPPORTED BY MEMBER'S DIAGNOSIS; L REPEATED PATTERNS OF UP-CODING AND/OR UNBUNDLING - RESULTS IN LRG PROV OVERPYMT; M UNEXPLAINABLE, SIGNIFICANT SPIKES IN CLAIMS VOLUMES AND REIMBURSEMENT; N BILLING FOR NUMEROUS DIAGNOSTICS WITH NO DOCUMENTATION FOR MEDICAL NECESSITY; O TERMINATED FOR CAUSE; P CONFIRMED BEOMB COMPLAINT THAT SERVICES WERE NOT DELIVERED; Q OTHER; Z NOT FRAUD AND ABUSE;
First Rpt SCDHHS	M	Date MCO First Reported to SCDHHS on the Monthly Report	Date	
Dt Fraud Referral Form Sent to DHHS	M	Date MCO Sent Fraud Referral Form to SCDHHS PI	Date	
SCDHHS Response	M	Return Response from SCDHHS	char(26)	Key: Referral to OAG; Accepted for SCDHHS Action; Returned to MCO for Action; Referral to Other Agency; Not Applicable
~~DLU~~ Dt Modified	M	Date Case Record Row Data Was Last Updated by MCO	Date	
Overpayment Amt Collected	Q	Amount of Overpayments Collected	Currency	
Notes	M	Additional comments	char(30)	
YR/QTR Ending (yyyy_qtr)	Q	Year and Quarter reported on	integer	
Recoveries from Cases	Q	Total of All Recoveries from All PI Related Cases	Currency	
Total Cost Avoidance	Q	Total Dollar Cost Avoided Due to PI Related Activities. (Cost Avoid is Determined by MCO Standards).	Currency	
All Other Recoveries	Q	Total Dollar from All Other PI Related Recoveries (ex. RAC and pharmacy audits)	Currency	
Total # Providers TFC	Q	Total Number of Providers Reported During the Quarter as Terminated For Cause	integer	
Total # Providers Denied Credentialing	Q	Total Number of Providers Reported During the Quarter as Denied Credentialing	integer	
***All information should be input as soon as the information becomes known.				
***The following fields may or may not be input depending on the type of review and review outcome. It is expected that all other fields should have an entry most of the time.				
Algorithm Name				
Total Paid During Review Period				
Estimated Dollars at Risk				
Overpayment Amt Determined				
Overpayment Adjusted Final Amt				
Amt Recovered				
Overpayment Amt Collected				
Case Closed				
Sanction1-4*				
Pymt Susp Begin				
Pymt Susp End				
*List SANCTIONS 1-4 in Order of Sanction Severity; 1-Highest Severity to 4-Lowest Severity				

Table 13.1.1: GME Report Template: Report is utilized for reporting payments to teaching hospitals for DHHS calculation of the Graduate Medical Education reimbursement.

Patient control #*	HMO claim #	Admission Date	Discharge Date	LOS	Discharge Status	Total Charges	DRG	Provider name	Provider Medicaid #	Reason for Recoupm
123456789	08888A888888	11/10/2006	11/12/2006	2	1	6,531.85	1251	ABC Hospital	111111	

*** Patient control#** - This was added at the request of the hospitals so that they can easily identify the claim to post the GME add on.

****Reason for Recoupment** - This is a new required field for any recouped claims. Please provide a description as to why this claim, which has been previously paid, is now being recouped. The claim number of the recouped claim should match a claim that has been previous paid. If a new claim number has been assigned, please put the original claim number is this column along with the reason for recoupment. This should NOT include any claims that have been reprocessed for rate changes. This should ONLY be for claims that have been paid and have now been recouped in total.

Blank GME Template

Patient control #*	HMO claim #	Admission Date	Discharge Date	LOS	Discharge Status	Total Charges	DRG	Provider name	Provider Medicaid #	Reason for Recoupment**

*** Patient control#** - This was added at the request of the hospitals so that they can easily identify the claim to post the GME add on.

****Reason for Recoupment** - This is a new required field for any recouped claims. Please provide a description as to why this claim, which has been previously paid, is now being recouped. The claim number of the recouped claim should match a claim that has been previous paid. If a new claim number has been assigned, please put the original claim number is this column along with the reason for recoupment. This should NOT include any claims that have been reprocessed for rate changes. This should ONLY be for claims that have been paid and have now been recouped in total.

Teaching Hospital Lists

	Teaching Hospitals before 10/1/07	
	Hospital Name	**IP Provider**
1	Anderson Area Medical Center	450780
2	Carolinas Medical Center	460403
3	Charleston Memorial Hospital	316258
4	Gaston Memorial Hospital	460595
5	Greenville Hospital System	111717
6	McLeod Regional Medical Center	459938
7	Medical College of Georgia	315846
8	Medical University Hospital	178277
9	Memorial Health University	117736
10	Palmetto Health Baptist Columbia	418962
11	Palmetto Health Richland	387175
12	Roper Hospital	400872
13	Self Regional Healthcare	417160
14	Spartanburg Regional Medical Center	369963
15	Tuomey Healthcare System	323436
16	University Hospital Augusta	150241

	Teaching Hospitals after 10/1/07	
1	Anderson Area Medical Center	450780
2	Carolinas Medical Center	460403
3	Charleston Memorial Hospital	316258
4	Greenville Hospital System	111717
5	McLeod Regional Medical Center	459938
6	Medical College of Georgia	315846
7	Medical University Hospital	178277
8	Memorial Health University	117736
9	Oconee Memorial Hospital	354027
10	Palmetto Health Baptist Columbia	418962
11	Palmetto Health Richland	387175
12	Roper Hospital	400872
13	Self Regional Healthcare	417160
14	Spartanburg Regional Medical Center	369963
15	St Francis Hospital	412885
16	Trident Medical Center	269338
17	Union Regional Medical Center	222150
18	University Hospital Augusta	150241

Teaching Hospital Lists Continued

Teaching Hospitals for discharges 10/01/08 and after			
	Hospital Name	**IP Provider**	
1	Aiken Regional Medical Center	226374	
2	Anderson Area Medical Center	450780	
3	Carolinas Medical Center	460403	
4	Greenville Hospital System	111717	
5	Lexington Medical Center	313118	
6	McLeod Regional Medical Center	459938	
7	Medical College of Georgia	315846	
8	Medical University Hospital	178277	
9	Oconee Memorial Hospital	354027	
10	Palmetto Health Baptist Columbia	418962	
11	Palmetto Health Richland	387175	
12	Roper Hospital	400872	
13	Self Regional Healthcare	417160	
14	Spartanburg Regional Medical Center	369963	
15	St Francis Hospital	412885	
16	Trident Medical Center	269338	
17	Union Regional Medical Center	222150	
18	University Hospital Augusta	150241	

Teaching Hospitals for discharges 10/01/09 and after

	Hospital Name	**IP Provider**
1	Aiken Regional Medical Center	226374
2	AnMed Health	450780
3	Carolinas Medical Center	460403
4	Greenville Hospital System	111717
5	Lexington Medical Center	313118
6	McLeod Regional Medical Center	459938
7	Medical College of Georgia	315846
8	Medical University Hospital	178277
9	Oconee Memorial Hospital	354027
10	Palmetto Health Baptist Columbia	418962
11	Palmetto Health Richland	387175
12	Roper Hospital	400872
13	Self Regional Healthcare	417160
14	Spartanburg Regional Medical Center	369963
15	St Francis Hospital	412885
16	Trident Medical Center	269338
17	Union Regional Medical Center	222150
18	University Hospital Augusta	150241

Teaching Hospital Lists Continued

Teaching Hospitals for discharges 10/01/10 and after			
	Hospital Name	**IP Provider**	
1	Aiken Regional Medical Center	226374	
2	AnMed Health	450780	
3	Carolinas Medical Center	460403	
4	Greenville Hospital System	111717	
5	Lexington Medical Center	313118	
6	McLeod Regional Medical Center	459938	
7	Medical College of Georgia	315846	
8	Medical University Hospital	178277	
9	Oconee Memorial Hospital	354027	
10	Palmetto Health Baptist Columbia	418962	
11	Palmetto Health Richland	387175	
12	Roper Hospital	400872	
13	Self Regional Healthcare	417160	
14	Spartanburg Regional Medical Center	369963	
15	St Francis Hospital	412885	
16	Trident Medical Center	269338	
17	Union Regional Medical Center	222150	
18	University Hospital Augusta	150241	

Teaching Hospitals for discharges 4/07/11 and after

	Hospital Name	**IP Provider**
1	Aiken Regional Medical Center	226374
2	AnMed Health	450780
3	Carolinas Medical Center	460403
4	Greenville Hospital System	111717
5	Lexington Medical Center	313118
6	McLeod Regional Medical Center	459938
7	Medical College of Georgia	315846
8	Medical University Hospital	178277
9	Oconee Memorial Hospital	354027
10	Palmetto Health Baptist Columbia	418962
11	Palmetto Health Richland	387175
12	Roper Hospital	400872
13	Self Regional Healthcare	417160
14	Spartanburg Regional Medical Center	369963
15	St Francis Hospital	412885
16	Trident Medical Center	269338
17	Union Regional Medical Center	222150
18	University Hospital Augusta	150241

Teaching Hospital Lists Continued

Teaching Hospitals for discharges 7/10/11 and afte		
	Hospital Name	**IP Provider**
1	Aiken Regional Medical Center	226374
2	AnMed Health	450780
3	Greenville Hospital System	111717
4	Lexington Medical Center	313118
5	McLeod Regional Medical Center	459938
6	Medical University Hospital	178277
7	Oconee Memorial Hospital	354027
8	Palmetto Health Baptist Columbia	418962
9	Palmetto Health Richland	387175
10	Roper Hospital	400872
11	Self Regional Healthcare	417160
12	Spartanburg Regional Medical Center	369963
13	St Francis Hospital	412885
14	Trident Medical Center	269338

Teaching Hospitals for discharges 10/01/11 and after

	Hospital Name	**IP Provider**
1	Aiken Regional Medical Center	226374
2	AnMed Health	450780
3	Greenville Hospital System	111717
4	Greer Memorial Hospital	440063
5	Hillcrest Hospital	418062
6	Lexington Medical Center	313118
7	McLeod Regional Medical Center	459938
8	Medical University Hospital	178277
9	Oconee Memorial Hospital	354027
10	Palmetto Health Baptist Columbia	418962
11	Palmetto Health Richland	387175
12	Patewood Memorial Hospital	AHTL90
13	Roper Hospital	400872
14	Self Regional Healthcare	417160
15	Spartanburg Regional Medical Center	369963
16	St Francis Hospital	412885
17	Trident Medical Center	269338

Teaching Hospital Lists Continued

Teaching Hospitals for discharges 11/01/12 and after

	Hospital Name	IP Provider
1	Aiken Regional Medical Center	226374
2	AnMed Health	450780
3	Greenville Hospital System	111717
4	Greer Memorial Hospital	440063
5	Hillcrest Hospital	418062
6	Lexington Medical Center	313118
7	McLeod Regional Medical Center	459938
8	Medical University Hospital	178277
9	Oconee Memorial Hospital	354027
10	Palmetto Health Baptist Columbia	418962
11	Palmetto Health Richland	387175
12	Patewood Memorial Hospital	AHTL90
13	Roper Hospital	400872
14	Self Regional Healthcare	417160
15	Spartanburg Regional Medical Center	369963
16	St Francis Hospital	412885
17	Trident Medical Center	269338

Discharge Status Codes

Status	Description
01	Discharged to home or self care (routine discharge)
02	Transferred to another short-term general hospital
03	Transferred to a SNF
04	Transferred to an ICF
05	Transferred to another type of institution
06	Discharged to home under care of an organized home health service organization
07	Left against medical advice
08	Discharge to home care under the care of a home IV therapy provider
20	Expired
30	Still patient or expected to return for outpatient services
31	Still patient - SNF administrative days program
32	Still patient - ICF administrative days program
62	Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part unit of a hospital
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

Section 14.10.8 – Capitation Rate Calculation Sheet (CRCS)

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June 6, 2016

Ms. Deirdra Singleton
Deputy Director of Health Programs
Department of Health and Human Services
State of South Carolina
P.O. Box 8206
1801 Main Street
Columbia, SC 29202-8206

RE: CRCS METHODOLOGY DOCUMENTATION UPDATE FOR ICD-10 CONVERSION – 06-06-2016

Dear Deirdra:

Milliman, Inc. (Milliman) has been retained by the South Carolina Department of Health and Human Services (SCDHHS) to provide actuarial and consulting services related to the Medicaid managed care program. Milliman was requested to assist in the development of an encounter monitoring report that was established in the contract between SCDHHS and the managed care organizations. This letter provides updates to the CRCS category assignment for the KICK rate cell. The modifications reflect the changes resulting from the ICD-10 diagnosis code conversion on October 1, 2015. In consultation with SCDHHS, a new list of ICD-10 diagnosis codes was developed for outpatient and physician categories of service related to the KICK rate cell assignment.

Enclosures 1, 2 and 3 included with this letter replace the respective enclosures included in the CRCS Methodology Documentation Update letter, dated December 11, 2015. All modifications related to this June 6, 2016 update are noted in yellow highlight. The updated KICK criteria applies to claims incurred on or after October 1, 2015 and should be reflected in the fourth quarter calendar year 2015 CRCS reports. All other items not related to the impact of the ICD-10 conversion on the CRCS reporting analysis remain unchanged from the December 11, 2015 correspondence.

LIMITATIONS

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and SCDHHS approved July 1, 2015. The information contained in this correspondence, including any enclosures, has been prepared for the SCDHHS, and its consultants and advisors.

It is our understanding that a copy of this letter with the enclosures may be shared with the managed care organizations (MCOs). To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for SCDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In performing this analysis, we relied on data and other information provided by SCDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

———— ◆ ◆ ◆ ◆ ————

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3548.

Sincerely,

Marlene T. Howard

Marlene T. Howard, FSA, MAAA
Consulting Actuary

MTH/sks
Enclosures

Enclosure 1

State of South Carolina
Department of Health and Human Services
MCO Reporting Manual
Capitation Rate Calculation Sheet

All updates for the ICD-10 conversion have been highlighted throughout each enclosure.

Category of Service	APR DRGs	Unit Measure
Inpatient Hospital		
IP Medical/Surgical/ Non-Delivery Maternity	001-532, 543-546, 561-625, 630-639, 650-724, 790-912, 930-931	Days
IP Well Newborn	626, 640	Days
Mental Health / Substance Abuse	740-776	Days
Other Inpatient	All claims containing a room and board revenue code (0100-0219) and not containing a DRG listed above are grouped into the Other Inpatient service category.	Days

Type of Service	Revenue Code	Other Information	Unit Measure
Outpatient Hospital			
Surgery		Surgery Claims are determined by CPT-4 procedure code taken from the 'Surgical Fee Schedule for 2010 2011 2012 2013' associated with the Hospital Services Provider Manual	Encounters
Non-Surg – Emergency Room	450-451		Encounters
Treatment/Therapy/Testing	170-171, 258, 260-261, 300-302*, 304-312*, 314*, 319-324*, 329-330*, 331-332, 333*, 335, 340-343*, 349-352*, 359*, 380-387, 390-391, 400-404*, 410, 412-413, 419, 420*, 424*, 430*, 434*, 440*, 444*, 459, 460, 469-472, 479, 481 482-483, 489, 610-612*, 614-616*, 618-619*, 634-636*, 721, 730-732, 739-740, 749, 750, 759, 820-821, 830-831, 840-841, 850-851, 900-901, 910, 914-916, 918, 920-922, 923*, 924, 929, 940, 943	Revenue codes or code ranges marked with a * require the claim to contain a valid HCPCS or CPT-4 procedure code ('TTT_Lab_Xray' and 'Fee Schedule for Hospital Outpatient for PT OT and Speech Therapy' lists associated with the Hospital Services Provider Manual) on the claim line	Encounters
Observation Room	761-762, 769		Encounters
Non-Surg – Other	510-517, 519		Encounters
Other Outpatient		Any services provided by Outpatient Hospital Providers and not assigned by Revenue Code or procedure code methodology.	Encounters

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Pharmacy			
Prescription Drugs	All Prescription Drugs Dispensed		Scripts
Ancillaries			
Ambulance	A0021, A0225-A0999, Q3019-Q3020, S0207-S0208		Claim Lines
Prosthetic/DME	99070, A4206-A4259, A4262-A4265, A4270-A4640, A4648-A8004, A9155, A9272-A9284, A9300, A9900-A9999, B4034-B9999, C9365-C9369, E0100-E8002, K0001-K0900, L0112-L9900, Q0478-Q0509, Q1003-Q1005, Q4001-Q4051, Q4100-Q4149, S0515, S1015-S1040, S1090, S5560-S5571, S8096-S8101, S8120-S8490, S8930, S8999-S9007, S9061, T2028, T4521-T4544, T5001, T5999, V2623-V2632, V2788, V5336		Units
Other Ancillaries	55970-55980, 58321-58323, 58970-58976, 69090, 89250-89398, 92325-92342, 92370, 97810-97814, 99071-99082, 99406, 99407, 99450-99456, 99500-99602, A0080-A0210, A4261, A4266-A4269, A9150-A9153, A9180-A9270, C1204-C9200, C9202-C9350, C9352-C9364, C9399-C9899, D0120-D9999, G0151-G0164, G0248-G0249, G0293-G0294, G0333, G0436-G0437, G0444, G0911-G8999, G9016, G9021-G9036, G9050-G9140, G9148-G9360, H1010, J7300-J7307, Q0090, Q0510-Q0514, Q2040, Q2043, Q2052, Q5001-Q5010, S0209-S0215, S0270-S0272, S0280-S0281, S0345-S0347, S0500-S0514, S0516-S0590, S0595-S0596, S0622, S0800-S0812, S1001-S1002, S4011-S4991, S4995, S5035-S5036, S5100- S5181, S5185, S5190, S5199, S5497-S5523, S9075, S9097-S9098, S9110, S9122-S9131, S9208-S9381, S9430, S9449, S9452-S9453, S9490-S9504, S9537-S9810, S9900-S9999, T1000-T2027, T2029-T2101, V2020-V2615, V2700-V2784, V2786-V2787, V5011-V5298		Units

Type of Service	CPT-4 / HCPCS Code	Other Information	Unit Measure
Physician			
Surgery - I/P and O/P	10000-36410, 36420-55920, 56405-58301, 58340-58960, 58999, 59525,	Excludes anesthesiologist services.	Units

	60000-69020, 69100-69990, 92920-92944, 92973-92974, 92980-92998, 93451-93462, 93501-93533, 93580-93583, G0127, G0168-G0173, G0251, G0259-G0260, G0267, G0269, G0289-G0291, G0297-G0305, G0339-G0343, G0364, G0392-G0393, G0412-G0415, G0440-G0441, G0455, M0301, S0400, S0601, S2053-S2118, S2135-S2152, S2205-S2235, S2270-S2900, S9034		
Surgery - I/P and O/P - Anesthesia	00100-00840, 00844-01953, 01962-01963, 01969-01999, 99100-99150	Or surgery services provided by an anesthesiologist as identified by a modifier.	Claim Lines
ER Visits	99217-99220, 99224-99226, 99234-99236, 99281-99288, G0378-G0384		Units
Hospital Visits	90816-90829, 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99289-99318, 99356-99357, 99436-99440, 99464-99476, 99478-99486 G0390, G0406-G0408, G0425-G0427, S0310		Units
Office Visits	98966-98969, 99201-99215, 99241-99245, 99324-99355, 99358-99359, 99361-99362, 99366-99380, 99441-99444, 99446-99449, 99499, G0179-G0182, G0337, S0220-S0260, S0273-S0274		Units
Immunizations	90460-90749, G0008-G0010, G0377, G9141-G9142, J3530, Q2035-Q2039, S0195		Units
Radiology	70000-79999, G0130, G0202-G0235, G0252, G0275-G0278, G0288, G0389, Q0092, R0070-R0076, S8030-S8037, S8042-S8092, S9024		Units
Pathology	36415-36416, 80000-89240, G0027, G0103, G0123-G0124, G0141-G0148, G0265-G0266, G0306-G0307, G0328, G0394, G0416-G0419, G0430-G0435, G0452, G0461-G0462, G9143, P2028-P7001, Q0091, Q0111-Q0115, Q3031, S2120, S3600-S3890, S9529		Units
Type of Service	**CPT – 4 / HCPCS Code**	**Other Information**	**Unit Measure**
Physician			
Mental Health/ Substance Abuse	90785-90815, 90832-90899, 99408-99409, G0129, G0176-G0177, G0396-G0397, G0409-G0411, G0442-G0443, H0001-H0050, H1011, H2000-H2037, M0064, S0201, S3005, S9475, S9480-S9485		Units

Maternity – Non-Delivery	59000-59350, 59425-59430, 59812-59866, 59870-59899, H1000-H1005, S0199, S2260, S2265-S2267, S4005	Any services containing the Maternity – Non-Delivery CPT-4 HCPCS codes and a maternity diagnosis code will be grouped with the Delivery Kick Payment categories.	Units
Other Professional Services		Any services provided by professional providers and not assigned by CPT-4 HCPCS methodology.	Units

Delivery Kick Payment Codes

Category of Service	APR DRGs	Unit Measure
Inpatient Hospital		
Inpatient Maternity Delivery	540, 541, 542, 560	Days

Type of Service	Diagnosis Codes	Other Information	Unit Measure
Outpatient Hospital			
Outpatient Hospital Maternity (ICD-9 Diagnosis Codes, Dates of Service before October 1, 2015)	Hospital Outpatient services with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5th digit being 1 or 2)		Claims
(ICD-10 Diagnosis Codes, Dates of Service on or after October 1, 2015)	Hospital outpatient services with a primary diagnosis codes of O6010X0-O6023X9, O610X0-O669, O68, O690XX0-O879, O8802, O8803, O8812, O8813, O8822, O8823, O8832, O8833, O8901-O899, O904, Z370-Z379. A complete listing of individual codes can be found in enclosure 2.		

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Maternity – Delivery	59400-59414, 59510-59515, 59610-59622		Claims
Maternity – Delivery - Anesthesia	00842, 01958-01961, 01965-01968	Or delivery services provided by an anesthesiologist as identified by a modifier.	Line Items
Maternity – Office Visits*	59425, 59426, 59430, 99212-99215		Units
Maternity – Radiology*	76801, 76802, 76805, 76810-76820, 76946		Units
Maternity – Non Delivery*	59000		Units

**Note: Maternity-related physician services require a diagnosis code from the following list Dates of Service Before October 1, 2015 (ICD-9 Codes) (first 3 characters only): v22, v23, v28, 640-648, 650-658, 671, 675, 676, and 683 to be included in the delivery Kick payment category.*
Dates of Service on or after October 1, 2015 (ICD-10 Codes): Please see enclosure 3 for a complete listing of ICD-10 diagnosis codes for maternity-related physician services.

Enclosure 2

All updates for the ICD-10 conversion have been highlighted throughout each enclosure.

*outpatient claims with ICD10 delivery diagnosis codes categorized as OP-Del.;

proc format;

invalue $ICD10O

'O6010X0'='Y'
'O6010X1'='Y'
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'O7582'='Y'
'O7589'='Y'
'O759'='Y'
'O76'='Y'
'O770'='Y'
'O771'='Y'
'O778'='Y'
'O779'='Y'
'O80'='Y'
'O82'='Y'
'O85'='Y'
'O860'='Y'
'O8611'='Y'
'O8612'='Y'
'O8613'='Y'
'O8619'='Y'
'O8620'='Y'
'O8621'='Y'
'O8622'='Y'
'O8629'='Y'
'O864'='Y'
'O8681'='Y'
'O8689'='Y'
'O870'='Y'
'O871'='Y'
'O872'='Y'
'O873'='Y'
'O874'='Y'
'O878'='Y'
'O879'='Y'
'O8802'='Y'
'O8803'='Y'
'O8812'='Y'
'O8813'='Y'
'O8822'='Y'
'O8823'='Y'
'O8832'='Y'
'O8833'='Y'
'O8901'='Y'
'O8909'='Y'
'O891'='Y'
'O892'='Y'
'O893'='Y'
'O894'='Y'
'O895'='Y'
'O896'='Y'
'O898'='Y'
'O899'='Y'
'O904'='Y'
'Z370'='Y'
'Z371'='Y'
'Z372'='Y'

'Z373'='Y'
'Z374'='Y'
'Z3750'='Y'
'Z3751'='Y'
'Z3752'='Y'
'Z3753'='Y'
'Z3754'='Y'
'Z3759'='Y'
'Z3760'='Y'
'Z3761'='Y'
'Z3762'='Y'
'Z3763'='Y'
'Z3764'='Y'
'Z3769'='Y'
'Z377'='Y'
'Z379'='Y'

other = 'N'; **run**;

*drg codes will map CRCS groups for inpatient data;

proc format;

```
invalue $aprdrg
'001'-'532' = 'IP-Med/Surg'
'543'-'546' = 'IP-Med/Surg'
'561'-'625' = 'IP-Med/Surg'
'630'-'639' = 'IP-Med/Surg'
'650'-'724' = 'IP-Med/Surg'
'790'-'912' = 'IP-Med/Surg'
'930'-'931' = 'IP-Med/Surg'

'626' = 'IP-WellNB'
'640' = 'IP-WellNB'

'740'-'776' = 'IP-MH/SA'

'950'-'999' = 'IP-Other'

'540'-'542' = 'IP-Del'
'560' = 'IP-Del'

other='ZZZ'
;
```

```
*revenue codes will map CRCS groups for outpatient data;

proc format library = stgfrmt.RateSettingFmts;

invalue $rev
/*OP-ER, OP-Obs, OP-NonSurg codes are taken from Hospital Services Provider Manual (Updated
November 4, 2015) on page 2-23 */
'0450' = 'OP-ER'
'0451' = 'OP-ER'

'0761' - '0762' = 'OP-Obs'
'0769' = 'OP-Obs'

'0510' - '0517' = 'OP-NonSurg'
'0519' = 'OP-NonSurg'

/*OP-TTT codes are taken from Hospital Services Provider Manual (Updated November 4, 2015) on page
4-2*/
'0170' = 'OP-TTT'
'0171' = 'OP-TTT'
'0258' = 'OP-TTT'
'0260' = 'OP-TTT'
'0261' = 'OP-TTT'
'0300' = 'OP-TTTP'
'0301' = 'OP-TTTP'
'0302' = 'OP-TTTP'
'0304' = 'OP-TTTP'
'0305' = 'OP-TTTP'
'0306' = 'OP-TTTP'
'0307' = 'OP-TTTP'
'0309' = 'OP-TTTP'
'0310' = 'OP-TTTP'
'0311' = 'OP-TTTP'
'0312' = 'OP-TTTP'
'0314' = 'OP-TTTP'
'0319' = 'OP-TTTP'
'0320' = 'OP-TTTP'
'0321' = 'OP-TTTP'
'0322' = 'OP-TTTP'
'0323' = 'OP-TTTP'
'0324' = 'OP-TTTP'
'0329' = 'OP-TTTP'
'0330' = 'OP-TTTP'
'0331' = 'OP-TTT'
'0332' = 'OP-TTT'
'0333' = 'OP-TTTP'
'0335' = 'OP-TTT'
'0340' = 'OP-TTTP'
'0341' = 'OP-TTTP'
'0342' = 'OP-TTTP'
'0343' = 'OP-TTTP'
'0349' = 'OP-TTTP'
'0350' = 'OP-TTTP'
```

'0351' = 'OP-TTTP'
'0352' = 'OP-TTTP'
'0359' = 'OP-TTTP'
'0380' = 'OP-TTT'
'0381' = 'OP-TTT'
'0382' = 'OP-TTT'
'0383' = 'OP-TTT'
'0384' = 'OP-TTT'
'0385' = 'OP-TTT'
'0386' = 'OP-TTT'
'0387' = 'OP-TTT'
'0390' = 'OP-TTT'
'0391' = 'OP-TTT'
'0400' = 'OP-TTTP'
'0401' = 'OP-TTTP'
'0402' = 'OP-TTTP'
'0403' = 'OP-TTTP'
'0404' = 'OP-TTTP'
'0410' = 'OP-TTT'
'0412' = 'OP-TTT'
'0413' = 'OP-TTT'
'0419' = 'OP-TTT'
'0420' = 'OP-TTTP'
'0424' = 'OP-TTTP'
'0430' = 'OP-TTTP'
'0434' = 'OP-TTTP'
'0440' = 'OP-TTTP'
'0444' = 'OP-TTTP'
'0459' = 'OP-TTT'
'0460' = 'OP-TTT'
'0469' = 'OP-TTT'
'0470' = 'OP-TTT'
'0471' = 'OP-TTT'
'0472' = 'OP-TTT'
'0479' = 'OP-TTT'
'0480' = 'OP-TTT'
'0481' = 'OP-TTT'
'0482' = 'OP-TTT'
'0483' = 'OP-TTT'
'0489' = 'OP-TTT'
'0610' = 'OP-TTTP'
'0611' = 'OP-TTTP'
'0612' = 'OP-TTTP'
'0614' = 'OP-TTTP'
'0615' = 'OP-TTTP'
'0616' = 'OP-TTTP'
'0618' = 'OP-TTTP'
'0619' = 'OP-TTTP'
'0634' = 'OP-TTTP'
'0635' = 'OP-TTTP'
'0636' = 'OP-TTTP'
'0721' = 'OP-TTT'
'0730' = 'OP-TTT'

```
'0731' = 'OP-TTT'
'0732' = 'OP-TTT'
'0739' = 'OP-TTT'
'0740' = 'OP-TTT'
'0749' = 'OP-TTT'
'0750' = 'OP-TTT'
'0759' = 'OP-TTT'
'0820' = 'OP-TTT'
'0821' = 'OP-TTT'
'0830' = 'OP-TTT'
'0831' = 'OP-TTT'
'0840' = 'OP-TTT'
'0841' = 'OP-TTT'
'0850' = 'OP-TTT'
'0851' = 'OP-TTT'
'0900' = 'OP-TTT'
'0901' = 'OP-TTT'
'0910' = 'OP-TTT'
'0914' = 'OP-TTT'
'0915' = 'OP-TTT'
'0916' = 'OP-TTT'
'0918' = 'OP-TTT'
'0920' = 'OP-TTT'
'0921' = 'OP-TTT'
'0922' = 'OP-TTT'
'0923' = 'OP-TTTP'
'0924' = 'OP-TTT'
'0929' = 'OP-TTT'
'0940' = 'OP-TTT'
'0943' = 'OP-TTT'

other='ZZZ'
;
run;
```

```
*Identify all claims containing Room & Board revenue codes as Inpatient Hospital;
*outpatient methodology coding based on South Carolina FFS Hospital Reimbursement Provider Manual;
*Summarize hospital (ub form) encounter claims to compare to health plan reported data;
*For IP claims with 0 days, determine if room and board rev codes are present on the claim. claims that
qualify
will stay in IP with total R&B units assigned for days.
claims that do not qualify will run through OP logic;


*take units from room and board line and assign to the claim;
data rb_lines;
set output.claims_mapped_&CURRQ.;
where revenue_code ge '0100' and revenue_code le '0219';
run;

*sum up units by claim if more than one R&B line. this way we'll count all the days from the claim;
proc summary nway missing data= rb_lines;
class enc_id_no;
var units_of_service;
output out= rb_summ(drop=_type_ )sum=;
run;

*make format statement to map units using the room and board units for days;
data day_Format(keep = FmtName Type Start Label hlo);
set rb_summ end=last;
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = units_of_service;
Type = 'J';
FmtName = 'days';
output;
if last then do;
Start = '';
Label = 'FALSE';
hlo = 'O';
output;
end;
run;

proc sort nodupkey data=day_Format;
by Start;
run;
proc format cntlin=day_Format;
run;
```

```
*first make distinction for ip vs op on ub claims;
data map_ip op;
set output.claims_mapped_&CURRQ.;
where enc_doc_type eq 'Z';
format RB_flag $1. CRCS_cat $12. days 12. M_units 12.;

*assign a flag if there is a room & board revenue code on a claim. this indicates it is IP;
if input(enc_id_no,$days.) ne 'FALSE' then RB_flag = 'Y';
        else RB_flag = 'N';

*calculate LOS;
days = datepart(TO_DATE) - datepart(DATE_OF_SERVICE); *note: variable days_procs is not
populated, so calc LOS;

*re-assign days if there isn't an original day count;
if days eq 0 and RB_flag eq 'Y' then days = input(enc_id_no,$days.);

*if 0 days and don't have room and board, then let it go to op;
if days eq 0 and RB_flag eq 'N' then output op;

*now we run the IP logic on the claims;
else do;

        CRCS_cat = input(drg_2014,$aprdrg.);

        if drg_2014 in ('540','541','542','560') then del_flag = M_claimcnt;
        else del_flag = 0;

        *if there isn't a valid drg on the claim, then send them to op, if there is one, then run through ip
logic;
        if CRCS_cat in ('ZZZ','IP-Other') and input(enc_id_no,$days.) eq 'FALSE' then output op;
        else do;
                *only count units/claims for the header line of the ip claim;
                if ENC_DETAIL_LINE_NO eq 1 then do;
                        M_mult = 1;
                        M_paid = TOTAL_AMT_PAID;
                        M_units = days;
                end;
                else do;
                        M_mult = 0;
                        M_units = 0;
                        M_paid = 0;
                end;
                if CRCS_cat eq 'ZZZ' then CRCS_cat = 'IP-Other';


                *zero out voids and 0 paids;
                if void_flag eq 'V' or (M_paid eq 0 and reimburse_method ne 'C') then do;
                        M_mult = 0;
                        M_units = 0;
                        M_paid = 0;
                        M_claimcnt = 0;
                        del_flag = 0; *Now zeroing out deliveries on voided claims too;
```

```
                end;

                output map_ip;
        end;
end;
run;


*label entire claim depending on revenue code (surg, ER, non-surg, obs room, TTT, other).
The order of importance is taken into account across a few steps;

*if ER or surg claim on any line, include entire claim as ER or surg;

*make format statement to identify claim number of Surg claims;
*Surgery procedure codes are taken from 'Surgical Fee schedule for 2010 2011 2012 2013' associated
with the hospital service provider manual.
data Surg_Format(keep = FmtName Type Start Label);
set op;
where input(procedure_code,$surgery.) eq 'Y';format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-Surg';
Type = 'J';
FmtName = 'Srgclm';
run;
proc sort nodupkey data=Surg_Format;
by Start;
run;
proc format cntlin=Surg_Format;
run;

*make format statement to identify claim number of ER claims;
data ER_Format(keep = FmtName Type Start Label);
set op;
where input(revenue_code,$rev.) eq 'OP-ER';
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-ER';
Type = 'J';
FmtName = 'ERclm';
run;
proc sort nodupkey data=ER_Format;
by Start;
run;
proc format cntlin=ER_Format;
run;

*make format statement to identify claim number of TTT claims;
*TTT claims that require a valid procedure code, have procedure codes taken from "TTT_Lab_Xray
Procedure Code Pricing" or "Fee Schedule for Outpatient Hospitals for CPT Codes for PT OT and
Speech Therapy", and both are associated with the Hospital Services Provider Manual.;

data TTT_Format(keep = FmtName Type Start Label);
set op;
```

```
where input(revenue_code,$rev.) eq 'OP-TTT' or (input(revenue_code,$rev.) eq 'OP-TTTP' and
input(procedure_code,$vproc.) eq 'Y');
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-TTT';
Type = 'J';
FmtName = 'TTTclm';
run;
proc sort nodupkey data=TTT_Format;
by Start;
run;
proc format cntlin=TTT_Format;
run;

*make format statement to identify claim number of TTTP claims;

data TTTP_Format(keep = FmtName Type Start Label);
set op;
where input(revenue_code,$rev.) eq 'OP-TTTP' and input(procedure_code,$vproc.) ne 'Y';
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-TTTP';
Type = 'J';
FmtName = 'TTTP';
run;
proc sort nodupkey data=TTTP_Format;
by Start;
run;
proc format cntlin=TTTP_Format;
run;

*make format statement to identify claim number of non-surgery other claims;
data nonsurg_Format(keep = FmtName Type Start Label);
set op;
where input(revenue_code,$rev.) eq 'OP-NonSurg';
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-NonSurg';
Type = 'J';
FmtName = 'nonsur';
run;
proc sort nodupkey data=nonsurg_Format;
by Start;
run;
proc format cntlin=nonsurg_Format;
run;

*make format statement to identify claim number of Observation Room claims;
data obs_Format(keep = FmtName Type Start Label);
set op;
where input(revenue_code,$rev.) eq 'OP-Obs';
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
```

```
Label = 'OP-Obs';
Type = 'J';
FmtName = 'Obsclm';
run;
proc sort nodupkey data=obs_Format;
by Start;
run;
proc format cntlin=obs_Format;
run;


*pull outpatient claims out of hospital types;
data map_op;
set op;
format CRCS_cat $12.;

CRCS_cat = input(revenue_code,$rev.);


if year_mo le '201509' then do;

*assign outpatient delivery claims per primary diagnosis code;
        if substr(PRIM_DIAG_CODE,1,4) eq ' V27' then do;
                CRCS_cat = 'OP-Del';
                if M_RateGrp ne 'DUAL' then M_Rategrp = 'KICK';
        end;
        else if PRIM_DIAG_CODE eq ' 650' then do;
                CRCS_cat = 'OP-Del';
                if M_RateGrp ne 'DUAL' then M_Rategrp = 'KICK';
        end;
        else if (PRIM_DIAG_CODE ge ' 65101') and (PRIM_DIAG_CODE le ' 66992') and
        substr(PRIM_DIAG_CODE,6,1) in ('1','2') then do;
                CRCS_cat = 'OP-Del';
                if M_RateGrp ne 'DUAL' then M_Rategrp = 'KICK';
        end;
end;
else do;

        if input(COMPRESS(PRIM_DIAG_CODE),$ICD10O.) = 'Y' then do;
                CRCS_cat = 'OP-Del';
                if M_RateGrp ne 'DUAL' then M_Rategrp = 'KICK';
        end;
end;

M_mult = 1;
M_units = units_of_service;
M_paid = TOTAL_AMT_PAID;

*if it's other, then we'll bucket ip vs op based on whether the health plan assigned it a DRG and if there
aren't any days on it;
*yep, this technically means there will be "IP" claims in my "OP" file... but that shouldn't matter in the
end;
if CRCS_cat in ('ZZZ','OP-Other') and DRG_2014 ne '' and days ne 0 then do;
```

```
        CRCS_cat = 'IP-Other';
        if ENC_DETAIL_LINE_NO eq 1 then do;
                M_mult = 1;
                M_units = days;
                M_paid = TOTAL_AMT_PAID;
        end;
        else do;
                M_mult = 0;
                M_units = 0;
                M_paid = 0;
                M_claimcnt = 0;
        end;
end;


else if CRCS_cat eq 'ZZZ' then CRCS_cat = 'OP-Other';

*we need the entire claim to be classified here. map using claim ID format;
*surg claims have priority if multiple are present. order of priority is:
surg, ER, non-surg, obs room, TTT, other;
*divide treatment/therapy/testing into TTT and other based on proc presence;
        if CRCS_cat = 'OP-Del' then CRCS_cat = 'OP-Del';
        else if input(enc_id_no,$Srgclm.) eq 'OP-Surg' then CRCS_cat = 'OP-Surg';
        else if input(enc_id_no,$ERclm.) eq 'OP-ER' then CRCS_cat = 'OP-ER';
        else if input(enc_id_no,$nonsur.) eq 'OP-NonSurg' then CRCS_cat = 'OP-NonSurg';
        else if input(enc_id_no,$Obsclm.) eq 'OP-Obs' then CRCS_cat = 'OP-Obs';
        else if input(enc_id_no,$TTTclm.) eq 'OP-TTT' then CRCS_cat = 'OP-TTT';
        else if input(enc_id_no,$TTTP.) eq 'OP-TTTP' then CRCS_cat = 'OP-Other';

        else CRCS_cat = 'OP-Other';

*zero out voids and 0 paids;
if void_flag eq 'V' or (M_paid eq 0 and reimburse_method ne 'C') then do;
        M_mult = 0;
        M_units= 0;
        M_paid = 0;
        M_claimcnt = 0;
end;

run;

*create and output data summaries for excel;
proc summary nway missing data= map_ip;
class M_Indiv_no year_mo M_PROD_ID M_rategrp CRCS_cat reimburse_method PROV_NUMBER;
var M_ClaimCnt M_mult M_units M_paid del_flag;
output out = outputdg.IP_Summ_&CURRQ.(drop=_type_ _freq_)sum=;
run;

proc summary nway missing data= map_op;
class M_Indiv_no year_mo M_PROD_ID M_rategrp CRCS_cat reimburse_method PROV_NUMBER;
var M_ClaimCnt M_mult M_units M_paid;
output out = outputdg.OP_Summ_&CURRQ.(drop=_type_ _freq_)sum=;
run;
```

Enclosure 3

All updates for the ICD-10 conversion have been highlighted throughout each enclosure.

```
proc format;

invalue $ICD10P

'Z331'='Y'
'Z3400'='Y'
'Z3401'='Y'
'Z3402'='Y'
'Z3403'='Y'
'Z3480'='Y'
'Z3481'='Y'
'Z3482'='Y'
'Z3483'='Y'
'Z3490'='Y'
'Z3491'='Y'
'Z3492'='Y'
'Z3493'='Y'
'O0900'='Y'
'O0901'='Y'
'O0902'='Y'
'O0903'='Y'
'O0910'='Y'
'O0911'='Y'
'O0912'='Y'
'O0913'='Y'
'O09211'='Y'
'O09212'='Y'
'O09213'='Y'
'O09219'='Y'
'O09291'='Y'
'O09292'='Y'
'O09293'='Y'
'O09299'='Y'
'O0930'='Y'
'O0931'='Y'
'O0932'='Y'
'O0933'='Y'
'O0940'='Y'
'O0941'='Y'
'O0942'='Y'
'O0943'='Y'
'O09511'='Y'
'O09512'='Y'
'O09513'='Y'
'O09519'='Y'
```

'O09521'='Y'
'O09522'='Y'
'O09523'='Y'
'O09529'='Y'
'O09611'='Y'
'O09612'='Y'
'O09613'='Y'
'O09619'='Y'
'O09621'='Y'
'O09622'='Y'
'O09623'='Y'
'O09629'='Y'
'O0970'='Y'
'O0971'='Y'
'O0972'='Y'
'O0973'='Y'
'O09811'='Y'
'O09812'='Y'
'O09813'='Y'
'O09819'='Y'
'O09821'='Y'
'O09822'='Y'
'O09823'='Y'
'O09829'='Y'
'O09891'='Y'
'O09892'='Y'
'O09893'='Y'
'O09899'='Y'
'O0990'='Y'
'O0991'='Y'
'O0992'='Y'
'O0993'='Y'
'O3680X0'='Y'
'O3680X1'='Y'
'O3680X2'='Y'
'O3680X3'='Y'
'O3680X4'='Y'
'O3680X5'='Y'
'O3680X9'='Y'
'Z36'='Y'
'O10011'='Y'
'O10012'='Y'
'O10013'='Y'
'O10019'='Y'
'O1002'='Y'
'O1003'='Y'
'O10111'='Y'
'O10112'='Y'
'O10113'='Y'
'O10119'='Y'
'O1012'='Y'
'O1013'='Y'
'O10211'='Y'

'O10212'='Y'
'O10213'='Y'
'O10219'='Y'
'O1022'='Y'
'O1023'='Y'
'O10311'='Y'
'O10312'='Y'
'O10313'='Y'
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'O1032'='Y'
'O1033'='Y'
'O10411'='Y'
'O10412'='Y'
'O10413'='Y'
'O10419'='Y'
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'O1043'='Y'
'O10911'='Y'
'O10912'='Y'
'O10913'='Y'
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'O1092'='Y'
'O1093'='Y'
'O111'='Y'
'O112'='Y'
'O113'='Y'
'O119'='Y'
'O1200'='Y'
'O1201'='Y'
'O1202'='Y'
'O1203'='Y'
'O1210'='Y'
'O1211'='Y'
'O1212'='Y'
'O1213'='Y'
'O1220'='Y'
'O1221'='Y'
'O1222'='Y'
'O1223'='Y'
'O131'='Y'
'O132'='Y'
'O133'='Y'
'O139'='Y'
'O1400'='Y'
'O1402'='Y'
'O1403'='Y'
'O1410'='Y'
'O1412'='Y'
'O1413'='Y'
'O1420'='Y'
'O1422'='Y'
'O1423'='Y'
'O1490'='Y'

'O1492'='Y'
'O1493'='Y'
'O1500'='Y'
'O1502'='Y'
'O1503'='Y'
'O151'='Y'
'O152'='Y'
'O159'='Y'
'O161'='Y'
'O162'='Y'
'O163'='Y'
'O169'='Y'
'O200'='Y'
'O208'='Y'
'O209'='Y'
'O210'='Y'
'O211'='Y'
'O212'='Y'
'O218'='Y'
'O219'='Y'
'O2300'='Y'
'O2301'='Y'
'O2302'='Y'
'O2303'='Y'
'O2310'='Y'
'O2311'='Y'
'O2312'='Y'
'O2313'='Y'
'O2320'='Y'
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'O2323'='Y'
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'O2332'='Y'
'O2333'='Y'
'O2340'='Y'
'O2341'='Y'
'O2342'='Y'
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'O88313'='Y'
'O88319'='Y'
'O8832'='Y'
'O8833'='Y'
'O88811'='Y'
'O88812'='Y'
'O88813'='Y'
'O88819'='Y'
'O8882'='Y'
'O8883'='Y'
'O91011'='Y'
'O91012'='Y'
'O91013'='Y'
'O91019'='Y'
'O9102'='Y'
'O9103'='Y'
'O91111'='Y'
'O91112'='Y'
'O91113'='Y'
'O91119'='Y'
'O9112'='Y'
'O9113'='Y'
'O91211'='Y'
'O91212'='Y'
'O91213'='Y'
'O91219'='Y'
'O9122'='Y'
'O9123'='Y'

'O92011'='Y'
'O92012'='Y'
'O92013'='Y'
'O92019'='Y'
'O9202'='Y'
'O9203'='Y'
'O92111'='Y'
'O92112'='Y'
'O92113'='Y'
'O92119'='Y'
'O9212'='Y'
'O9213'='Y'
'O9220'='Y'
'O9229'='Y'
'O923'='Y'
'O924'='Y'
'O925'='Y'
'O926'='Y'
'O9270'='Y'
'O9279'='Y'

other = 'N'; run;

*procedure codes will map CRCS groups for professional data;
*updated to reflect 2014 HCPCS codes;

proc format;

invalue $cpt

/*ancillary*/
'A0021' = 'Anc-Amb'
'A0225'-'A0999' = 'Anc-Amb'
'Q3019'-'Q3020' = 'Anc-Amb'
'S0207'-'S0208' = 'Anc-Amb'

'99070' = 'Anc-DME'
'A4206'-'A4259' = 'Anc-DME'
'A4262'-'A4265' = 'Anc-DME'
'A4270'-'A4640' = 'Anc-DME'
'A4648'-'A8004' = 'Anc-DME'
'A9155' = 'Anc-DME'
'A9272'-'A9284' = 'Anc-DME'
'A9300' = 'Amc-DME'
'A9900'-'A9999' = 'Anc-DME'
'B4034'-'B9999' = 'Anc-DME'
'C9365'-'C9369' = 'Anc-DME'
'E0100'-'E8002' = 'Anc-DME'
'K0001'-'K0900' = 'Anc-DME'
'L0112'-'L9900' = 'Anc-DME'
'Q0478'-'Q0509' = 'Anc-DME'
'Q1003'-'Q1005' = 'Anc-DME'

'Q4001'-'Q4051' = 'Anc-DME'
'Q4100'-'Q4149' = 'Anc-DME'
'S0515' = 'Anc-DME'
'S1015'-'S1040' = 'Anc-DME'
'S1090' = 'Anc-DME'
'S5560'-'S5571' = 'Anc-DME'
'S8096'-'S8101' = 'Anc-DME'
'S8120'-'S8490' = 'Anc-DME'
'S8930' = 'Anc-DME'
'S8999'-'S9007' = 'Anc-DME'
'S9061' = 'Anc-DME'
'T2028' = 'Anc-DME'
'T4521'-'T4544' = 'Anc-DME'
'T5001' = 'Anc-DME'
'T5999' = 'Anc-DME'
'V2623'-'V2632' = 'Anc-DME'
'V2788' = 'Anc-DME'
'V5336' = 'Anc-DME'
'55970'-'55980' = 'Anc-Other'
'58321'-'58323' = 'Anc-Other'
'58970'-'58976' = 'Anc-Other'
'69090' = 'Anc-Other'
'89250'-'89398' = 'Anc-Other'
'92325'-'92342' = 'Anc-Other'
'92370' = 'Anc-Other'
'97810'-'97814' = 'Anc-Other'
'99071'-'99082' = 'Anc-Other'
'99406'-'99407' = 'Anc-Other'
'99450'-'99456' = 'Anc-Other'
'99500'-'99602' = 'Anc-Other'
'A0080'-'A0210' = 'Anc-Other'
'A4261' = 'Anc-Other'
'A4266'-'A4269' = 'Anc-Other'
'A9150'-'A9153' = 'Anc-Other'
'A9180'-'A9270' = 'Anc-Other'
'C1204'-'C9200' = 'Anc-Other'
'C9202'-'C9350' = 'Anc-Other'
'C9352'-'C9364' = 'Anc-Other'
'C9399'-'C9899' = 'Anc-Other'
'D0120'-'D9999' = 'Anc-Other'
'G0151'-'G0164' = 'Anc-Other'
'G0248'-'G0249' = 'Anc-Other'
'G0293'-'G0294' = 'Anc-Other'
'G0333' = 'Anc-Other'
'G0436'-'G0437' = 'Anc-Other'
'G0444' = 'Anc-Other'
'G0911'-'G8999' = 'Anc-Other'
'G9016' = 'Anc-Other'
'G9021'-'G9036' = 'Anc-Other'
'G9050'-'G9140' = 'Anc-Other'
'G9148'-'G9360' = 'Anc-Other'
'H1010' = 'Anc-Other'
'J7300'-'J7307' = 'Anc-Other'

'Q0090' = 'Anc-Other'
'Q0510'-'Q0514' = 'Anc-Other'
'Q2040' = 'Anc-Other'
'Q2043' = 'Anc-Other'
'Q2052' = 'Anc-Other'
'Q5001'-'Q5010' = 'Anc-Other'
'S0209'-'S0215' = 'Anc-Other'
'S0270'-'S0272' = 'Anc-Other'
'S0280'-'S0281' = 'Anc-Other'
'S0345'-'S0347' = 'Anc-Other'
'S0500'-'S0514' = 'Anc-Other'
'S0516'-'S0590' = 'Anc-Other'
'S0595'-'S0596' = 'Anc-Other'
'S0622' = 'Anc-Other'
'S0800'-'S0812' = 'Anc-Other'
'S1001'-'S1002' = 'Anc-Other'
'S4011'-'S4991' = 'Anc-Other'
'S4995' = 'Anc-Other'
'S5035'-'S5036' = 'Anc-Other'
'S5100'-'S5181' = 'Anc-Other'
'S5185' = 'Anc-Other'
'S5190' = 'Anc-Other'
'S5199' = 'Anc-Other'
'S5497'-'S5523' = 'Anc-Other'
'S9075' = 'Anc-Other'
'S9097'-'S9098' = 'Anc-Other'
'S9110' = 'Anc-Other'
'S9122'-'S9131' = 'Anc-Other'
'S9208'-'S9331' = 'Anc-Other'
'S9336'-'S9338' = 'Anc-Other'
'S9340'-'S9381' = 'Anc-Other'
'S9430' = 'Anc-Other'
'S9449' = 'Anc-Other'
'S9452'-'S9453' = 'Anc-Other'
'S9490'-'S9504' = 'Anc-Other'
'S9537'-'S9810' = 'Anc-Other'
'S9900'-'S9999' = 'Anc-Other'
'T1000'-'T2027' = 'Anc-Other'
'T2029'-'T2101' = 'Anc-Other'
'V2020'-'V2615' = 'Anc-Other'
'V2700'-'V2784' = 'Anc-Other'
'V2786'-'V2787' = 'Anc-Other'
'V5011'-'V5298' = 'Anc-Other'

/*physician*/
'00100'-'00840' = 'Phys-Anes'
'00844'-'01953' = 'Phys-Anes'
'01962'-'01963' = 'Phys-Anes'
'01969'-'01999' = 'Phys-Anes'
'99100'-'99150' = 'Phys-Anes'

'99217'-'99220' = 'Phys-ER'
'99224'-'99226' = 'Phys-ER'

'99234'-'99236' = 'Phys-ER'
'99281'-'99288' = 'Phys-ER'
'G0378'-'G0384' = 'Phys-ER'

'90816'-'90829' = 'Phys-Hosp'
'99221'-'99223' = 'Phys-Hosp'
'99231'-'99233' = 'Phys-Hosp'
'99238'-'99239' = 'Phys-Hosp'
'99251'-'99255' = 'Phys-Hosp'
'99289'-'99318' = 'Phys-Hosp'
'99356'-'99357' = 'Phys-Hosp'
'99436'-'99440' = 'Phys-Hosp'
'99464'-'99476' = 'Phys-Hosp'
'99478'-'99486' = 'Phys-Hosp'
'G0390' = 'Phys-Hosp'
'G0406'-'G0408' = 'Phys-Hosp'
'G0425'-'G0427' = 'Phys-Hosp'
'S0310' = 'Phys-Hosp'

'90460'-'90749' = 'Phys-Imm'
'G0008'-'G0010' = 'Phys-Imm'
'G0377' = 'Phys-Imm'
'G9141'-'G9142' = 'Phys-Imm'
'J3530' = 'Phys-Imm'
'Q2033'-'Q2039' = 'Phys-Imm'
'S0195' = 'Phys-Imm'

'90785'-'90815' = 'Phys-MH/SA'
'90832'-'90899' = 'Phys-MH/SA'
'99408'-'99409' = 'Phys-MH/SA'
'G0129' = 'Phys-MH/SA'
'G0176'-'G0177' = 'Phys-MH/SA'
'G0396'-'G0397' = 'Phys-MH/SA'
'G0409'-'G0411' = 'Phys-MH/SA'
'G0442'-'G0443' = 'Phys-MH/SA'
'H0001'-'H0050' = 'Phys-MH/SA'
'H1011' = 'Phys-MH/SA'
'H2000'-'H2037' = 'Phys-MH/SA'
'M0064' = 'Phys-MH/SA'
'S0201' = 'Phys-MH/SA'
'S3005' = 'Phys-MH/SA'
'S9475' = 'Phys-MH/SA'
'S9480'-'S9485' = 'Phys-MH/SA'

'59000'-'59350' = 'Phys-NonDel'
'59425'-'59430' = 'Phys-NonDel'
'59812'-'59866' = 'Phys-NonDel'
'59870'-'59899' = 'Phys-NonDel'
'H1000'-'H1005' = 'Phys-NonDel'
'S0199' = 'Phys-NonDel'
'S0260' = 'Phys-NonDel'
'S2265'-'S2267' = 'Phys-NonDel'
'S4005' = 'Phys-NonDel'

'98966'-'98969' = 'Phys-OV'
'99201'-'99215' = 'Phys-OV'
'99241'-'99245' = 'Phys-OV'
'99324'-'99355' = 'Phys-OV'
'99358'-'99359' = 'Phys-OV'
'99361'-'99362' = 'Phys-OV'
'99366'-'99380' = 'Phys-OV'
'99441'-'99444' = 'Phys-OV'
'99446'-'99449' = 'Phys-OV'
'99499' = 'Phys-OV'
'G0179'-'G0182' = 'Phys-OV'
'G0337' = 'Phys-OV'
'S0220'-'S0260' = 'Phys-OV'
'S0273'-'S0274' = 'Phys-OV'

'36415'-'36416' = 'Phys-Path'
'80000'-'89240' = 'Phys-Path'
'G0027' = 'Phys-Path'
'G0103' = 'Phys-Path'
'G0123'-'G0124' = 'Phys-Path'
'G0141'-'G0148' = 'Phys-Path'
'G0265'-'G0266' = 'Phys-Path'
'G0306'-'G0307' = 'Phys-Path'
'G0328' = 'Phys-Path'
'G0394' = 'Phys-Path'
'G0416'-'G0419' = 'Phys-Path'
'G0430'-'G0435' = 'Phys-Path'
'G0452' = 'Phys-Path'
'G0461'-'G0462' = 'Phys-Path'
'G9143' = 'Phys-Path'
'P2028'-'P7001' = 'Phys-Path'
'Q0091' = 'Phys-Path'
'Q0111'-'Q0115' = 'Phys-Path'
'Q3031' = 'Phys-Path'
'S2120' = 'Phys-Path'
'S3600'-'S3890' = 'Phys-Path'
'S9529' = 'Phys-Path'

'70000'-'79999' = 'Phys-Rad'
'G0130' = 'Phys-Rad'
'G0202'-'G0235' = 'Phys-Rad'
'G0252' = 'Phys-Rad'
'G0275'-'G0278' = 'Phys-Rad'
'G0288' = 'Phys-Rad'
'G0389' = 'Phys-Rad'
'Q0092' = 'Phys-Rad'
'R0070'-'R0076' = 'Phys-Rad'
'S8030'-'S8037' = 'Phys-Rad'
'S8042'-'S8092' = 'Phys-Rad'
'S9024' = 'Phys-Rad'

'10000'-'36410' = 'Phys-Surg'

'36420'-'55920' = 'Phys-Surg'
'56405'-'58301' = 'Phys-Surg'
'58340'-'58960' = 'Phys-Surg'
'58999' = 'Phys-Surg'
'59525' = 'Phys-Surg'
'60000'-'69020' = 'Phys-Surg'
'69100'-'69990' = 'Phys-Surg'
'92920'-'92944' = 'Phys-Surg'
'92973'-'92974' = 'Phys-Surg'
'92980'-'92998' = 'Phys-Surg'
'93451'-'93462' = 'Phys-Surg'
'93501'-'93533' = 'Phys-Surg'
'93580'-'93583' = 'Phys-Surg'
'G0127' = 'Phys-Surg'
'G0168'-'G0173' = 'Phys-Surg'
'G0251' = 'Phys-Surg'
'G0259'-'G0260' = 'Phys-Surg'
'G0267' = 'Phys-Surg'
'G0269' = 'Phys-Surg'
'G0289'-'G0291' = 'Phys-Surg'
'G0297'-'G0305' = 'Phys-Surg'
'G0339'-'G0343' = 'Phys-Surg'
'G0364' = 'Phys-Surg'
'G0392'-'G0393' = 'Phys-Surg'
'G0412'-'G0415' = 'Phys-Surg'
'G0440'-'G0441' = 'Phys-Surg'
'G0455' = 'Phys-Surg'
'M0301' = 'Phys-Surg'
'S0400' = 'Phys-Surg'
'S0601' = 'Phys-Surg'
'S2053'-'S2118' = 'Phys-Surg'
'S2135'-'S2152' = 'Phys-Surg'
'S2205'-'S2235' = 'Phys-Surg'
'S2270'-'S2900' = 'Phys-Surg'
'S9034' = 'Phys-Surg'

/*delivery codes*/
'59400'-'59414' = 'Phys-Del'
'59510'-'59515' = 'Phys-Del'
'59610'-'59622' = 'Phys-Del'

'00842' = 'Phys-AnesDel'
'01958'-'01961' = 'Phys-AnesDel'
'01965'-'01968' = 'Phys-AnesDel'

THE FOLLOWING REQUIRES PREGNANCY DIAGNOSIS

Invalue $delcpt

‘59425’=’Phys-Del OV’
‘59426’=’Phys-Del OV’
‘59430’=’Phys-Del OV’
‘99212-99215’=’Phys-Del OV’

‘76801’=’Phys-Del Rad’
‘76802’=’Phys-Del Rad’
‘76805’=’Phys-Del Rad’
‘76810-76820’=’Phys-Del Rad’
‘76946’=’Phys-Del Rad’

‘59000’=’Phys-NonDel’

other = 'Phys-other'
;

run;

```
*summarize professional (HCFA form) encounter claims to compare to health plan reported data;


data outputdg.map_prof;
        set output.claims_mapped_&CURRQ.;
        where enc_doc_type in ('A','C');
        format CRCS_cat $14.;

*Assign CRCS_Cat of claims where there is a pregnancy diagnosis code with a maternity procedure code;

ARRAY DIAGS{*}  prim_diag_code  other_diag_code other_diag_code2-other_diag_code8;
if year_mo le '201509' then do;
        do i=1 to dim(diags);
        if substrn(compress(DIAGS{i}),1,3) in (&PregnancyDiagnosis.) and
input(procedure_code,$delcpt.) ne 'Phys-other' then do;

        CRCS_cat = input(procedure_code,$delcpt.);
        if M_RateGrp ne 'DUAL' then M_RateGrp = 'KICK';

                        end;
                end;
        end;
else do;
        do i=1 to dim(diags);
        if input(compress(DIAGS{i}),$ICD10P.) = 'Y' and input(procedure_code,$delcpt.) ne 'Phys-
other' then do;

        CRCS_cat = input(procedure_code,$delcpt.);
        if M_RateGrp ne 'DUAL' then M_RateGrp = 'KICK';

                end;
        end;
end;

*now check modifiers/provider types to be sure delivery/anesthesia are on claims;

        *anesthesia proc mod codes from HCG code set 20091231-set surgery codes w/ anesthesia mod
to be 'phys-anes';
        if CRCS_cat eq 'Phys-Surg' and PROC_CODE_MODIFIER in ('23','47','AA','AD','G8','QK','QS')
then CRCS_cat = 'Phys-Anes';


        *before we assign anesthesia, we need to throw out delivery codes that had an invalid provider;

        if CRCS_cat eq 'Phys-Del' and PROC_CODE_MODIFIER in ('23','47','AA','AD','G8','QK','QS')
then CRCS_cat = 'Phys-AnesDel';


if CRCS_cat eq 'ZZZ' then CRCS_cat = 'Phys-Other';


*zero out voids;
if void_flag eq 'V' or (TOTAL_AMT_PAID eq 0 and reimburse_method ne 'C') then do;
```

```
        M_mult = 0;
        M_units = 0;
        M_paid = 0;
        M_claimcnt = 0;
end;
*map units otherwise;
else do;
        M_mult = 1;
        M_units = units_of_service;
        M_paid = TOTAL_AMT_PAID;
end;

run;


*create and output data summaries for excel;
proc summary nway missing data= map_prof;
class M_Indiv_no year_mo M_PROD_ID M_rategrp CRCS_cat reimburse_method PROV_NUMBER;
var M_ClaimCnt M_mult M_units M_paid;
output out = output.Prof_Summ_&CURRQ.(drop=_type_ _freq_)sum=;
run;
```

Capitation Rate Calculation Sheet (CRCS) Report Template:

MCOs are required to submit quarterly Capitation Rate Calculation Sheet (CRCS) reports to SCDHHS. Below is a sample of the template and the full template can be found at: https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates
The template workbook has sheets for each rate category.
The reporting schedule can be found in the MCO P&P.

State of South Carolina
Department of Health and Human Services
MCO Reporting Manual
Capitation Rate Calculation Sheet (CRCS)

MCO Name:	**ABC Healthplan**
Reporting Period (Runout):	**January 2015 - June 2015 (Paid through September 2015)**
Region:	**Statewide**
Rate Category:	**TANF: 0-2 Months**
Member Months In The Reporting Quarter:	**0**

		Plan Reported					
		A	B1	B2	C	D	E
Category of Service	**Units**	**# of Units**	**Amount Paid**	**Estimated Subcapitated Amount Paid**	**Annual Utilization per 1,000**	**Cost per Unit**	**Service Cost PMPM**
Inpatient Hospital							
I/P Medical/Surgical/Non-Delivery Maternity	Days	-	$ 0	$ 0	-	$ 0.00	$ 0.00
I/P Well Newborn	Days	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Mental Health / Substance Abuse	Days	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Other Inpatient	Days	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Outpatient Hospital							
Surgery	Encounters	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Non-Surg - Emergency Room	Encounters	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Non-Surg - Other	Encounters	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Observation Room	Encounters	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Treatment/Therapy/Testing	Encounters	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Other Outpatient	Encounters	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Pharmacy							
Prescription Drugs	Scripts	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Ancillaries							
Ambulance	Claim Lines	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Prosthetic/DME	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Other Ancillaries	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Physician							
Surgery - I/P and O/P	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Surgery - I/P and O/P - Anesthesia	Claim Lines	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Maternity – Non-Delivery	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Hospital Visits	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Office Visits	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
ER Visits	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Immunizations	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Radiology	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Pathology	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Mental Health / Substance Abuse	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
Other Professional	Units	-	$ 0	$ 0	-	$ 0.00	$ 0.00
SUM OF COVERED SERVICES		-	$ 0	$ 0	-	N/A	$ 0.00

Model Attestation Letter
Attestation for Capitated Rate Calculation Sheet (CRCS)

(Company Letter Head)
Attestation for Reports

Date_____

I, _____, as (Title) for (Name of Company), do hereby attest, based upon my best knowledge, information and belief, that the data provided in the Capitated Rate Calculation Sheet (CRCS) are accurate, true, and complete.

I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to liquidated damages, sanctions and/or fines as outlined in Section 18 of the contract.

_____ _____
Signature/Title Date

REPORT REQUIREMENTS

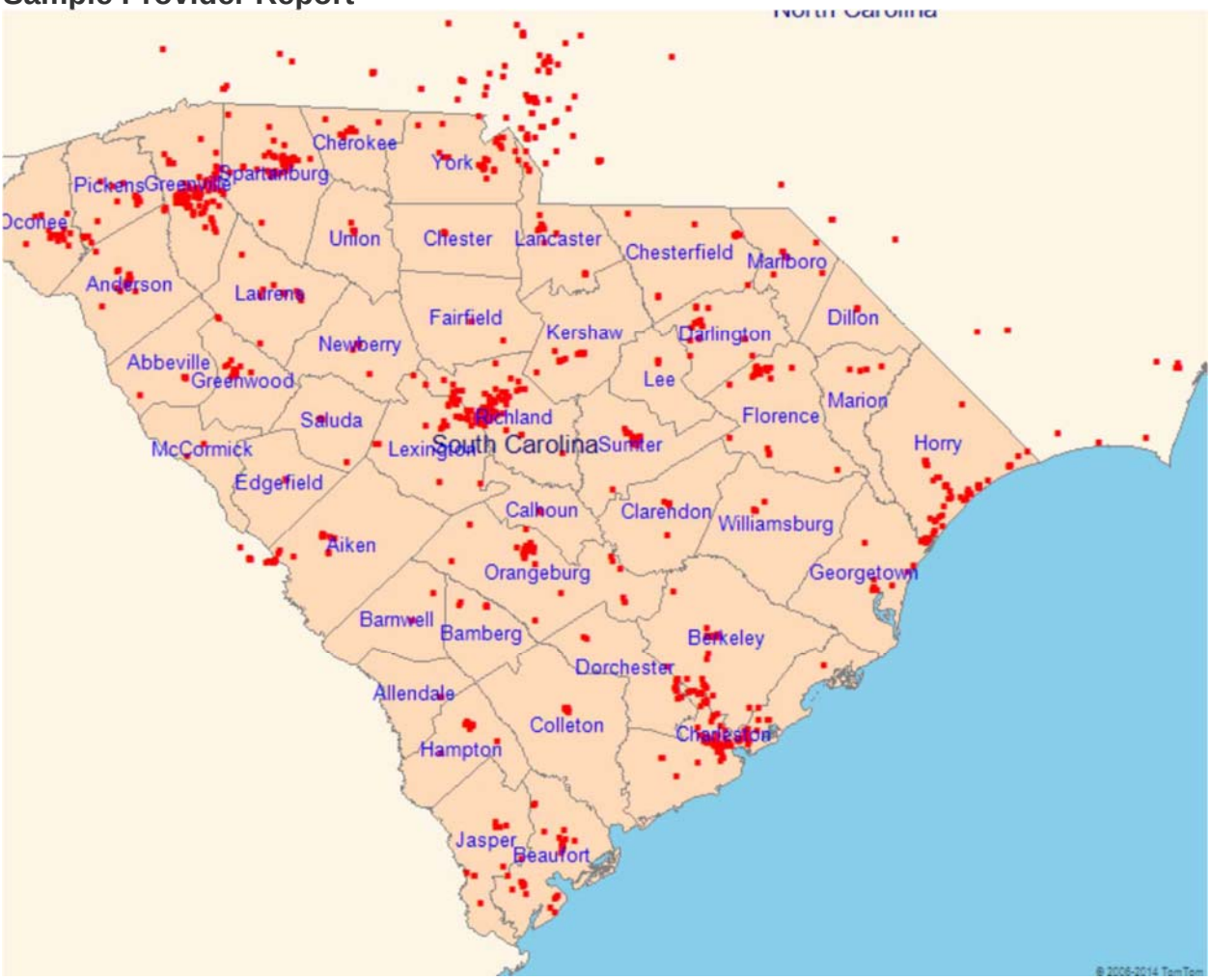
BI-ANNUAL/ANNUAL

Managed Care Report Name	Format	Report Timing
Semi-Annual and Annual Reporting Requirements		
Section 2		
Section 2.1.10		
Organizational Chart	Specific Format not defined. MCO can utilize any format it chooses to present the data. Must be submitted within 10 business days of change in personnel.	Annually and Upon Change in Personnel
Section 6		
Section 6.3.1 through 6.3.3.3		
Geoaccess	Sample Map and description of additional data required for report.	Bi-annually and as required
Section 7		
Section 7.4.3.2		
FQHC RHC Wrap Payments Annual	Current FQHC/RHC reports required for wrap payment process Annual Reconciliation.	Annually
Section 11		
Section 11.2.12		
PI Written Compliance Plan	Specific Format not defined MCO can utilize any format it chooses to present the data. This report should be submitted directly to Program Integrity's SharePoint site.	Annually
Section 14		
Section 14.8		
FQHC RHC Wrap Payments Annual	See section 7.4.3.2	Annually
Section 15		
Section 15.4 through 15.5		
HEDIS and CAHPS	NCQA defined	Annually
Section 15.7		
VOC	Value Oriented Contracting Form	Annually

Section 2.1.10 Organizational Charts: There is no specific required format for this annual report. See Contract and P&P for details. Please upload the annual report to the MCO's Annual library in SharePoint.

Section 6.3.1 through 6.3.3.3: Geoaccess Report: The specific required format for this report is reflected below. Please upload these reports bi-annually by September 1 and March 1 respectively and to the MCO's Annual library in SharePoint, and whenever changes are required to the report, upload to the Required Submissions library in SharePoint.

Sample Provider Report



Data Accompanying Maps

Accessibility Analysis Specifications	
Provider Group	Description of Provider Type, number of providers and number of locations
Members Group	Number of members in designated area.
Access Standard	Medicaid access standard utilized to run report.
Members with desired Access	Total Number of members with desired access.

Average distance to a choice of provider for members with desired access					
Number of providers	**1**	**2**	**3**	**4**	**5**
Miles					

Key geographic areas				
County	**Total number of members**	**Members without desired access**		
		Number	**Percent**	**Average distance to 1 provider**

Section 7.4.3.2 FQHC/RHC Summary Annual Reconciliation: Please see the specific required format for this report. Please upload this report to the MCO's annual library in SharePoint.

SUMMARY DATA - FIELD DESCRIPTIONS

Summary data is provided in a separate file in MS Excel file format. The field names, descriptions, length of field and field types are presented in field number order. Fee-for-service (FFS) and capitation (CAP) encounter/claims detail data are summarized by month and year of service for specified dates of service in the quarter. Capitation payments (fields 8 & 9) to include any additional or enhanced MCO per member per month payments (i.e. non fee for service) must be provided by the MCO. Fields 10-14 are calculated using information obtained from the encounter/claims detail data

Field	Data Element Number/Name	Example Length/Field Type	Description
1	MCO Name	ABC MCO (Text-30)	MCO name.
2	MCO Provider Number	HM9999 (Text-6)	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the MCO.
3	Legacy Number	RHC000 or FQC000 (Text-6)	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the FQHC or RHC.
4	NPI Number	9999999999 (Number-10)	The National Provider Identification number assigned to the FQHC or RHC.
5	Name	ABC Health Care (Text-50)	FQHC or RHC provider legal name.
6	Tax ID	99-99999999 (Text-10)	The federal tax identification number assigned to the FQHC or RHC.
7	Month/Year of Service	01/2008 (Date-7)	Enter the month and year of service in the appropriate format.
8	Monthly CAP Number of Members	99,999 (Number-5)	Enter the total number of members for month of service with capitation payments .
9	Monthly CAP Amount Paid	$99,999,999.99 (Number-10)	Enter the total amount paid for field 8. Field 9 is also to be used for any additional or enhanced MCO per member per month payments (i.e. non fee for service) if applicable.
10	Monthly FFS Number Members	99,999 (Number-5)	Enter the **unduplicated** number of members for month of service with fee-for-service payments .
11	Monthly FFS Number Encounters	99,999 (Number-5)	Enter the total number of fee-for-service encounters for month of service. **One encounter is a member's visit to the FQHC or RHC for each date of service regardless of the cpt4 code or status of the claim.** SCDHHS calculates the actual number of allowed fee-for-service encounters per member.
12	Monthly FFS Amount Paid	$99,999,999.99 (Number-10)	Enter the total amount paid for fee-for-service payments per month of service.
13	Monthly CAP Encounters Number Members	99,999 (Number-5)	Enter the unduplicated number of members for month of service with CAP encounter data only.
14	Monthly CAP Encounters Number of Encounters	999,999 (Number-6)	Enter the total number of CAP encounters for month of service. **One encounter is a member's visit to the FQHC or RHC for each date of service regardless of the cpt4 code or status of the claim.** SCDHHS calculates the actual number of allowed CAP encounters per member.
15	Monthly Co-Pay Totals	$99999.99 (Number-7) or 9999 (Number-4)	Enter the total amount of co-payments for the month of service or the total toal number of co-payments for the month of service.

ATTACHMENT 4

SUMMARY DATA - ACTUAL LAYOUT

Summary data is provided in a separate file in MS Excel file format. Each FQHC or RHC will have **one record per month/year of service**. Fields 8 - 9 must be provided by the MCO; the encounter/claims detail data does not contain this information. Fields 10 - 14 are summarized using encounter/claims detail data (Attachments 1 & 2).

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
						Summarize by Month/Year								
MCO Name	MCO Provider Number	Legacy Number	NPI Number	Name	Tax ID	Month/Year of Service	CAP No. Members	CAP Amount Paid	FFS No. of Clients	FFS No. Encounters	FFS Amount Paid	CAP Encounters - No. Clients	CAP Encounters - No. Encounters	Co-Pay Amount Paid or # of Co-Pays
ABC MCO	HM9999	RHC000	9999999999	ABC Health Care	99-9999999	01/2008	99,999	$99,999,999.99	99,999	99,999	$99,999,999.99	99,999	999,999	99999.99/9999

Section 11.2.12: Program Integrity Written Compliance Plan:
This report should be uploaded directly to PI via the PI SharePoint site annually and whenever changes are required to the report.

The PI Written Compliance Plan with DHHS comments is below.

The PI Written Compliance Plan template for MCOs to complete can be found at: https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

	2016 COMPLIANCE PLAN MATRIX
11.1.1	Develop and maintain a Compliance Plan to guard against FWA (42 CFR 438.608(a)).
DHHS Comment:	**Refer to 11.2** **A Medicaid Managed Care Compliance Program is… "A set of procedures and processes instituted by a managed care entity to regulate its internal processes and train staff to conform to and abide by applicable state and federal regulations which govern the managed care entity."** **The Compliance Program should also include those systems, procedures and policies by which the MCO will seek to prevent, identify and recover improper payments to and fraud and abuse on the part of its network providers and subcontractors.**
11.1.2	Have sufficient organizational capacity (administrative and management arrangements or procedures) to guard against FWA (42 CFR 438.608(a)). Specifically, adequate staffing and resources needed to fulfill the Program Integrity and Compliance requirements of this Contract; to investigate all reported incidents; and to develop and implement the necessary systems and procedures to assist the CONTRACTOR in preventing and detecting potential FWA.
DHHS Comment:	**Refer to 11.2.1 and 11.2.3, Staff** **A Compliance Plan is… "A written document that details the means by which an organization will conform to specific regulations to achieve and maintain compliance."** **The Plan:** • **Defines standards** • **Describes the methods for monitoring standards** • **Identifies corrective action processes** **The Compliance Plan should fully describe the MCO's Compliance program; should include all methods used by the MCO to prevent and identify fraud and abuse on the part of network providers and subcontractors; and should detail how the MCO will carry out the program integrity provisions established by section 11 of the July 2014 contract. Where the Compliance Plan must include a specific policy or policies, the written policy must be included in either the body of the Compliance Plan or as an appendix.**
11.1.3	Establish a Compliance Committee that is accountable to senior management (42 CFR 438.608(b)(2)). The Compliance Committee shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.

DHHS Comment:	**Refer to 11.2.2**
11.1.4	Effective lines of communication between the Compliance Officer, the Compliance Committee, and the CONTRACTOR's employees, Subcontractors, and Providers (42 CFR 438.608(b)(4)).
DHHS Comment:	**Refer to 11.2.6**
11.1.7	Have provisions for internal monitoring and auditing that provide for independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable federal and state laws and regulations (42 CFR 438.608(b)(6)).
DHHS Comment:	**Refer to 11.2.8**
11.1.9	Have provisions for prompt response to detected offenses, and for development of corrective action initiatives (42 CFR 438.608(b)(7)).
DHHS Comment:	**Refer to 11.2.9**
11.1.13	Have effective training and education for the Compliance Officer and the organization's employees and subcontractors (42 CFR 438.608(b)(3)). The training must comply with requirements of § 6032 of the Federal Deficit Reduction Act of 2005.
DHHS Comment:	**Refer to 11.2.5**
11.1.14	Establish, publish, and enforce disciplinary standards and guidelines for the CONTRACTOR's employees.
DHHS Comment:	**Refer to 11.2.7**
11.1.16	Upon notification by the Department that a provider has been placed on a payment suspension due to a credible allegation of fraud pursuant to 42 CFR § 455.23, CONTRACTOR must suspend payments to contracted providers and/or administrative entities involved. CONTRACTOR shall effectuate this suspension as soon as is practicable.
DHHS Comment:	**Explain the Suspension process. If a non-par provider, how do you restrict future enrollment and payments? How do you preform check holds?**
11.1.17	Withhold payment to a Provider as warranted for recoupment.

DHHS Comment:	**Describe the process for withholding payments to a Provider as warranted for recoupment. Explain the suspension process, withholding of payments and future enrollment and payment suspensions for non-par providers.**
11.1.22	Generate individual notices (a.k.a. Beneficiary Explanation of Medicaid Benefits (BEOMB)) within forty-five (45) calendar days of the payment of claims, to all or a statistically valid sample group of the Medicaid Managed Care Members who received services under the CONTRACTOR's Health Plan. Such notices must be sent on a semi-annual basis. The notice must not specify confidential services as defined by the Department, within the Managed Care Policy and Procedure Manual, and must not be sent if the only service furnished was confidential.
DHHS Comment:	**Describe the process for confirming Members received services billed.**
	COMPLIANCE PLAN
11.2	The CONTRACTOR shall create and maintain a Compliance Plan that addresses, at a minimum, the following requirements:
11.2.1	Compliance Officer The designation and identification of a Compliance Officer that is accountable to senior management.
DHHS Comment:	**Identify the Compliance Officer in writing in the Plan, with contact information (telephone # and email address).** **PI would also like the identification of the Program Integrity Coordinator with contact information (telephone # and email address).**
11.2.2	Compliance Committee Establishment of a Compliance Committee that is accountable to senior management is required. The Compliance Committee shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
DHHS Comment:	**Refer to 11.1.3** **Show the names and titles of the members of the Compliance Committee.** **Attach the Compliance Committee Operating Rules or Charter.**
11.2.3	Administrative and Managerial Capacity Pursuant to Section 2 of this Contract, the CONTRACTOR shall include an organizational chart in its Compliance Plan. The chart must include the names and job functions for all CONTRACTOR

	staff involved in program integrity and other activities designed to identify and protect against FWA.
DHHS Comment:	**Program Integrity shall include the SIU, Program Integrity, Fraud Recovery Unit, Payment Integrity Unit or any such designate unit recovering overpayment dollars relating to fraud, waste or abuse.**
11.2.4	Written Policies, Procedures and Standards of Conduct The Compliance Plan must include written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable Federal and State standards and regulations.
DHHS Comment:	**This includes how the Plan will comply with the Employee Education about False Claim Act requirements established by the Deficit Reduction Act of 2005, and how it will endure that its providers/ subcontractors do the same. Operational standards are the measurements by which the organization's processes will be assessed for compliance.**
11.2.4.1	A list of automated pre-payment (PreR) claims edits designed to ensure proper payment of claims and prevent payment of improper claims,
DHHS Comment:	**For example, list of NCCI edits, Global surgery code edits, etc.**
11.2.4.2	Internal operating procedures for desk audits or post-payment (PostR) review of claims,
DHHS Comment:	**Any procedures defining the desk audit or post-payment review process.** **These could be the procedures as defined in your Fraud, Waste and Abuse Plan or as delivered during the CMS audit.**
11.2.4.3	A list of reports of Provider profiling and credentialing used to aid program and payment integrity reviews,
DHHS Comment:	**A list of reports used to as a control mechanism to ensure that only qualified providers render services. Describe how the credentialing process helps the MCO prevent the enrollment of fraudulent providers.**
11.2.4.4	A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services,
DHHS Comment:	**Describe protocols for how the MCO monitors for medically-necessary utilization of services and establishes appropriate utilization controls. For example, the Beneficiary Pharmacy Lock-In Program, QIO, or contracted services.**
11.2.4.5	A list of references in Provider and Member materials regarding fraud and abuse referrals,
DHHS Comment:	**Information in the Provider/Member Handbooks regarding how to make a fraud referral.**
11.2.4.6	A list of provisions for the confidential reporting of CONTRACTOR violations.

DHHS Comment:	**Explain the process for employees to confidentially report CONTRACTOR violations. Include any policies and procedures as well as references in the employee handbook.**
11.2.4.7	Methods to ensure that the identities of individuals reporting violations of the CONTRACTOR are protected and that there is no retaliation against such persons.
DHHS Comment:	**Provide policies and procedures.**
11.2.4.8	Specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating Compliance Plan violations.
DHHS Comment:	**Provide policies and procedures and any associated forms used to report violations. Explain who conducts the investigation and the steps used to ensure confidentiality of the reporter.**
11.2.4.9	Pursuant to the Deficit Reduction Act of 2005 (DRA), written policies for employees detailing:
11.2.4.10	The Federal False Claims Act provisions,
DHHS Comment:	
11.2.4.11	The administrative remedies for false claims and statements,
DHHS Comment:	
11.2.4.12	Any federal or state laws described in 1902(a)(68) of the Act, relating to civil or criminal penalties for false claims and statements,
DHHS Comment:	
11.2.4.13	The whistleblower protections under such laws.
DHHS Comment:	

11.2.5	Training and Education The Compliance Plan must outline training and education for the Compliance Officer, and the organization's employees and subcontractors. The training and education activities must, at a minimum, address the following requirements:
DHHS Comment:	**Refer to 11.1.3** **This should be a description of the training, either within the Plan itself or as an appendix, used for the Compliance Officer and Organization's employees and subcontractors. Must be shown in the Plan (not enough just to write that you have one.) Must meet the requirements of § 6032 of the DRA as well as include any other program integrity-related training for the MCO's compliance and SIU staff. Should include training schedule and number of training or CPE's required for staff, if applicable.** **See actual training Plan.** **1. Attach provider handbook, provider training agendas or other activities that show how the MCO provides this information and education on correct billing to providers/ subcontractors.** **2. Describe how providers are educated n correct billing practices.** **Contractor must provide for effective training and education for the compliance officer and the organization's employees.** **Staffing education should:** • **Convey overall organizational standards for integrity** • **Convey the organization's commitment to compliance** • **Explain the purpose and importance of complying with applicable federal and state regulations.** **It should:** • **Alleviate employee fear of certain retribution for providing information regarding organizational practices, but emphasizing compliance expectations** • **Include mechanism for obtaining anonymous information** • **Educate employee regarding policies and procedures on wrongdoing and other acts subject to criminal scrutiny** • **Train staff regarding appropriate program regulations and organizational standards, provide process for staffing updates regarding new or modified regulations in a timely manner** • **Emphasize the importance of on-going monitoringEducate management regarding how effectively formulate and implement corrective action plans.**
11.2.5.1	Compliance with the requirements of § 6032 of the Federal Deficit Reduction Act of 2005.

DHHS Comment:	**How do you comply with the DRA?**
11.2.5.2	Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid Program Integrity.
DHHS Comment:	
11.2.5.3	Ensure that all of its officers, directors, managers, and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan.
DHHS Comment:	**Describe how the Plan ensures all of its officers, directors, managers, and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan. Attach any policies and procedures or handbooks.**
11.2.5.4	Outline activities for Provider education of federal and state laws and regulations related to Medicaid Program Integrity, and how the CONTRACTOR will identify and educate providers targeted for patterns of incorrect billing practices and/or overpayments.
DHHS Comment:	
11.2.5.5	Evaluate the performance of training and education activities and report to the Department on an annual basis the results of this assessment and the CONTRACTOR's work plan for enhancing all training and education activities based on the results of the assessment.
DHHS Comment:	
11.2.6	Lines of Communication Effective lines of communication between the Compliance Officer and the CONTRACTOR's employees, subcontractors, and providers must be established, clearly explained, and managed.
DHHS Comment:	**Organizational chart, written policies, work flow diagram, or any other documentation that shows how employees, subcontractors, and providers communicate with the Compliance Officer. Process must be in place for receiving, interpreting, distributing, and implementing regulatory guidance.** **Provider must be able to:**

	• **Demonstrate that training on communication extends to subcontractors and Providers.** • **Include organizational charts, written policies and work flow diagrams or other documents that outline how employees, subcontractors and Providers communicate with the Compliance Officer.** • **Include written policies or other documents that outline how employees, subcontractors and Providers report suspected activities.** • **Include the confidential reporting of Plan violations to a designated person.** • **Demonstrate that the Department's toll-free fraud hotline phone number (1-888-364-3224), the Department's fraud hotline email address (fraudres@scdhhs.gov) have been published in all employee handbooks, Provider manuals, and Member communications, mass communications, and MCO websites. Member communications are further defined in this guide as mass mailings including but not limited to member newsletters, benefit change notifications, or any other distribution affecting large segments of the MCO membership.** • **Demonstrate that the information has been placed in a prominent position so that Members may easily identify the information in the material.**
11.2.7	Enforcement & Accessibility Enforcement of standards for the CONTRACTOR's employees through well-publicized disciplinary guidelines.
DHHS Comment:	**Refer to 11.1.14** **Do you have publicized disciplinary guidelines? How/where are they publicized? Attach a copy.** **Mechanisms need to be in place to :** • **Identify, investigate and refer suspected fraud and abuse cases** • **Identify how assessments will be made** • **Associate specific punishment for specific offenses** **Enable staff to report suspect activities – including a hotline or anonymous comment cards**

11.2.8	Internal Monitoring and Auditing Provisions for internal monitoring and auditing which provide for independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable federal and state laws and regulations.
DHHS Comment:	**Refer to 11.1.7** **Information about the MCO's Internal Audit department and the types of external audits regularly performed of the MCO, which are used by management to determine the above. This can be at the corporate level and not just for the MCO's South Carolina business.** **Monitoring is the process of evaluating the organization's practices against set criteria such as program regulations and internal standards. It aids in the assessment and identification of areas of risk and vulnerability.** **2 components:** • **Internal auditsReports**
11.2.9	Response & Corrective Action Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract.
DHHS Comment:	**Refer to 11.1.9** **MCO's human resource policies and procedures or other internal operating policies and procedures.** **Corrective action plans:** • **Written planned objectives or measures to rectify a deficiency or non-compliant situation** • **Identify the standards/regulation** • **State the deficiency** • **Identify the measures that will be taken to rectify the situationIdentify timeframes for the remedy**

11.2.10	Provider Review and Audit Standards Provisions for provider reviews and audits must be consistent with the Department's Program Integrity review and auditing standards and instructions and/or guidance included within the Managed Care Policy and Procedure Manual.
DHHS Comment:	**Attach any policy and procedures relating to provider reviews and audits as a result of fraud, waste and abuse activities.**
11.2.11	Data Mining, Analysis and Reporting The Compliance Plan must describe the CONTRACTOR's process for conducting analyses of its provider and utilization data. This description must comply with the following standards:
11.2.11.1	A general description of the data mining and analyses performed by the CONTRACTOR,
DHHS Comment:	
11.2.11.2	A description of the individual reports—their purpose, objectives, and frequencies—associated with all FWA activities and requirements.
DHHS Comment:	
11.2.11.3	A description of the data used for data mining activities,
DHHS Comment:	**Describe the data sets used.**
11.2.11.4	A description of the procedural controls employed to guarantee the data is exclusive to the CONTRACTOR's South Carolina Medicaid Member population,
DHHS Comment:	
11.2.11.5	A description of the methods and/or techniques used to mine and analyze the data and how those approaches ensure alignment with the various procedural standards and reporting requirements of this Contract, Including:
11.2.11.5.1	Standards cited within this Contract and other documents associated with the program integrity provisions of this Contract (e.g., Managed Care Policy and Procedure Manual, Reports

	Companion Guide, and other Federal, State or Department Memos, Bulletins, Notices, Guidance documents or technical instruction manuals).
DHHS Comment:	
11.2.11.5.2	Standards specified in ad hoc requests issued by the Department and/or other Authorities (e.g., HHS, CMS, OIG, AG, and Others).
DHHS Comment:	
11.2.11.6	A description of findings/results produced for each analysis performed,
DHHS Comment:	
11.2.11.7	A description of the CONTRACTOR's approach to quality assurance with data mining and analysis, including:
DHHS Comment:	**Describe your QA processes and procedures for ensuring quality assurance when performing data analytics. To what extent does your QA process include policy, clinical and technical considerations to confirm findings?**
11.2.11.7.1	Measures used to assess and appraise the performance of the processes and procedures,
DHHS Comment:	**Describe any measures or methods used to assess the success of your QA process.**
11.2.11.7.2	Measures used to assess and appraise the quality of the results or findings,
DHHS Comment:	**Describe any measures or methods to assess the quality of data analytic results.**
11.2.11.7.3	Measures used to assess and evaluate the audits and reviews conducted with results or findings from the aforementioned reports.
DHHS Comment:	**What measures are used to evaluate the benefit from a given report?**
11.2.12	Process to confirm the identity and determine the exclusion status of any Provider and/or Subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO entity through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the system for Award Management (SAM), and any other databases as

	the Department or Secretary may prescribe (e.g. Department's SC List of Excluded Providers). These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the CONTRACTOR determines a match, it must promptly notify the Department, Division of Program Integrity and take any necessary actions consistent with 42 CFR §438.610 Prohibited affiliations.
DHHS Comment:	**Describe the confirmation process in detail. Which division conducts the checks? If there is a credible match, what steps are taken?**
11.2.12.1	The CONTRACTOR must detail the process for performing a monthly check for exclusions of its owners, agents and managing employees. Such processes must be consistent with the Managed Care Policy and Procedures Guidelines.
DHHS Comment:	

Section 14.8: FQHC and RHC Annual Reconciliation: Please see section 7.2.2. Please upload this report to the MCO's annual library in SharePoint and whenever changes are required to the report.

Section 15.4 through 15.5: HEDIS and CAHPS Reports: These reports are NCQA defined reports and should follow the reporting requirements NCQA utilizes. Please upload these reports to the MCO's annual library in SharePoint. The attestation form for these reports must accompany them and is reflected below.

SCDHHS Requirements and Specifications for the Submission of HEDIS and CAHPS Results

I, the undersigned, do hereby attest, based on my knowledge, information, and belief, that the data contained in the following submissions is accurate, truthful, and complete:

- The final, auditor-locked version of the IDSS submitted to NCQA containing the HEDIS measures reported by the MCO to NCQA for South Carolina Medicaid members
- The HEDIS Final Audit Report (FAR)
- Results of the CAHPS surveys that were administered to South Carolina Medicaid Members and submitted final, member-level, adult and child CAHPS Survey data files

Signature of CEO, CFO, or delegated authority:	
Print Name:	Date:
Name of MCO:	
Name of File(s) Submitted:	

Section 15.7: Value Oriented Contracting Form: This report should be utilized by the MCO's to reflect value oriented contracts. The certification should be submitted to VOC@scdhhs.gov.

Policy XXX **Attachment 1**

Value Oriented Contracting (VOC) Certification

MCO Name: _____

Measurement Period: _____

Claims Service Type	SCDHHS Accepted Encounter Data Total Expenditures	MCO Financial Data Expenditures	MCO Financial Data Pursuant to VOC	% VOC
Inpatient Hospital Claims				--
Outpatient Hospital Claims				--
Professional Claims (CMS 1500)				--
SubTotals	$ -	$ -	$ -	

Pass-Through Payment Type	SCDHHS Total Expenditures	MCO Total Expenditures	MCO Financial Data Pursuant to VOC	% VOC
Patient-Centered Medical Home				--
Centering				--
SubTotals	$ -	$ -	$ -	

Total VOC %	--

Signature Title

Print Name Date

Instructions:

Input data into the green cells, as indicated in the chart.

Data elements in salmon colored cells will calcualte automatically.

The measurement period should be a full calendar year.

The certification should be submitted to (VOC@scdhhs.gov).

The claims types in the top section of this form will mirror your usual claims types.

Appendix A

Reporting Sent Through FTP Site

Basic rules for exchanging Electronic Data Interchange (EDI) files between South Carolina Department of Health and Human Services (SCDHHS) and a Managed Care entity will adhere to the following guidelines. These guidelines will work in conjunction with other documentation contained within this document. Additional documentation may be provided during implementation.

NAMING CONVENTIONS

These files are proprietary files.
Files follow these naming conventions.
XXXXXX.YYYYYYYY
where XXXXXX is the provider number assigned by DHHS (ex: HM0500)
where YYYYYYYY is a descriptive extension of up to 8 characters (does not have to be 8, but at most, 8 characters). May not always contain this node.

EXAMPLE: HM0500.ENCOUN.TEST
Each node name (between the '.') has a max of eight characters.

ACTUAL FILES SENT TO SCDHHS FROM MCO

XXXXXX.PROV (SENT VIA EDI)
This file must precede 837 and/or NCPDP submission of the encounters. So the same day you send your encounter file, you may also submit this non par provider file along with your 837 or NCPDP file. This will be sent via your EDI box (this is sent to the same place and via the same mode of transportation as your 837 and/or NCPDP). This is not a cumulative file. This file should only contain new non par providers (ones that you have not used and sent to SCDHHS before and modified/corrected non par providers who have had some changes since you all have sent us their info). If you do not have any new non par providers or any modifications, you do not have to send this file. No control file is needed when sent to the EDI box.

XXXXXX.TPL (SENT VIA C:D)
This full/complete file of all TPL info for each recipient for that given month is required to be submitted to DHHS by the 8th of the month. This file must be submitted even if you have no input. In the case of no input, a blank file must be submitted to SCDHHS.

837 (SENT VIA EDI)
Each submission must be coordinated with DHHS. Basically send Jeff Helliges an email telling him how many files and the total number of records you uploaded to the EDI box. There is not a standard naming convention. The translator will prepend and append data to the input file name, so we ask that the TP's file name not be too long. Try to keep it under 30 characters if possible. Maybe something like:

SC837IN_CCCCMMDD_SEQ_X12.txt (Institutional file)
SC837PR_CCCCMMDD_SEQ_X12.txt (Professional file)

This file is requested no later than the 25th of the month. You may submit daily if you wish but please do not submit files on Fridays, Saturdays or Sundays. There is a 5,000 record limit per file and a 10 file max per day (so 50,000 records per day max).

XXXXXX.FQHCRHC.SUMMARY (SENT VIA C:D)
This will be your monthly wrap payment summary file and will be due by the 25th of the month.

XXXXXX.CAP.PAYMENTS (SENT VIA C:D)
This will be your monthly capitated payment summary file and will be due by the 25th of the month. For example, if your MCO has 30 doctors that it sends a capitated payment each month, then there must be a record for each of the 30 doctors in this file, regardless of how many members each of these doctors sees during the month. The figures in this file represent monthly NET totals. If by chance you run into negative amounts, then you would use the capitated payment void file because SCDHHS cannot accept negative amounts.

XXXXXX.CAP.PAYMENTS.VOID (SENT VIA C:D)
This will be your monthly capitated void payment summary file and will be due by the 25th of the month. If you have no capitated payment voids, then you do NOT need to send this file every month.

FILES UPLOADED:

Files may be uploaded at any point in time during a day. Files uploaded will be processed during the night. If possible please do not upload files Saturday and Sunday.

All proprietary files will be required to have a control file associated with it. Control file details are contained in the SCDHHS document named: 0016 Use of control files for EDI.doc. **NO CONTROL FILE IS REQUIRED FOR YOUR EDI FILES SENT TO YOUR EDI BOX.** Control files are required only for any proprietary files sent via connect direct.

ACTUAL FILES AND FILE NAMES SENT TO MCO FROM SCDHHS

ZZZZZZ.ZZZZ.ZZZZZ (VIA EDI)
This is the return encounter file sent back to the MCO. This is sent after processing which is usually 1 business day. This will be sent via your EDI box in the form of a 277CA. You will get back an initial 277 which tells you if your submission passed compliance on all 837s. You will then get back another 277 after your encounters have processed. NCPCP submissions will only get back the 277 after their encounters have processed. The second 277 will contain the edits.

XXXXXX.CLAIMS.HISTORY (VIA C:D)
Historical Fee for Service (FFS) claims not encounter data. This file contains the prior 24 months of FFS claims data for each member in your cutoff MLE file. History for those assigned to the plan between cutoff and the 1st of the month will be included in the following months FFS claims history extract. This file is also sent on or about the 5th of every month.

*The claims history file created after cutoff would give you about a 3 - 4 week lag in data because the claims history process uses the FFS archive files. An example of this is in the February 2010 claims history files created on or around February 25th, the most current FFS claim we had was January 26, 2010. So basically you are not getting any FFS claims from January 27, 2010 forward.

*When we ran the claims history file on March 3, 2010, we were able to get all FFS claims from February 22, 2010 back. So basically we only had a lag of 9 days. Because we have to wait until the FFS archive files are created to get the most current FFS data, this is about as close as we can get to having current data to give to the MCOs.

*The claims history file for the MHNs is called SURE.CLAIMS.

XXXXXX.ENCOUNT.CLAIMHST (VIA C:D)
This is 24 months of encounter data for your recipients. This file is sent on or around the 5th of every month.

XXXXXX.ENCOUNT.VOIDHST (VIA C:D)
This is a file of any void encounters for your recipients. This file is sent on or around the 5th of every month.

MCXXXXXX (VIA C:D)
This is a complete provider file created at MGC cutoff.

RSXXXXXX (VIA C:D)
This is the MLE file created at MGC cutoff. It is also created on the 1st of the month. The 1st file is still an MLE but has special significance. During the MGC cutoff run some recipients will be auto closed. These recipients will be reviewed and if necessary reinstated. All of those reinstated will be reported in this file.

Example:

During the cutoff run of August some recipients are auto closed. This means that the MCO will not get paid for them. During DHHS review, they are reinstated. They will be included in the MLE produced on the 1st of September. When the MGC cutoff run is completed for September (approximately the 3rd week), the MCO will receive two premium payments. One will be retro for the payment missed in August and the second payment will be for the current month of September. The MCO will be able to identify the retro payment. "If the member regains eligibility within 60 days of the disenrollment date, the member will be automatically re-enrolled with the Contractor. If eligibility is regained after 60 days of the disenrollment date, the member will need to contract SCDHHS to initiate re-enrollment."

Also of importance to note, retro payment for newborns will be included in the MLE at MGC cutoff.

XXXXXX.EPSDT.HIC (VIA C:D)
A special EPSDT system was developed, by DHHS, when the Federal EPSDT system was shut down. There are two files created with visit codes. One set for office visits and one set for injections. These files are created after the last payment run of the month. There is only 1 file that is sent on the last day of the month.

XXXXXX.REVIEW.FILE (VIA C:D)
Monthly file for re-certification is prepared by the 5th of each month. The recertification file contains the MCO's recipients whose Medicaid eligibility will be up for recertification (review/re-determination/renewal) in 1 month.

XXXXXX.IMMUN.FILE (VIA C:D)
SCDHHS gets the immunization file from DHEC around the 2nd Monday of the month. In that are all the eligible recipients for your MCO that has a record at DHEC of getting a shot. There are no date parameters on this file. It contains all shots on record at DHEC for your recipients. After we get the file, we will upload it for each MCO.

XXXXXX.RSS2170 (VIA C:D)
This is the daily membership file sent every weekday to each MCO with any changes to their membership. Sent by Maximus to each plan.

Monthly files for pricing information and procedure codes. These files are prepared by the 5th of each month and sent via connect direct.

CAR.CODE – list of carrier codes
RATE.FILE – provider contract rates
FEE.SCHD—procedure codes

XXXXXX.NPI.CRSSJUNC (VIA C:D)
This is the NPI Crosswalk Junction file sent every weekday to each MCO.

NOTIFICATION:

The MCO is required to notify DHHS, via E-mail, when files are ready to be processed. DHHS will notify the MCO, via E-mail, when files are ready for the MCO to download. The exception to this is, there is no notification at this time for HIPAA/EDI transactions. Details of this process will be exchanged at time of business startup. Basically, DHHS will provide an address for messages to be addressed to. The MCO will need to provide an address for DHHS to send messages to.

HIPAA FILE NAMING CONVENTION:

RUNNUMBER.EDI where 'RUNNUMBER' = an eight digit number assigned by the translator when the file is put in the mailbox. This number has no intelligence associated with it. They are usually sent out the first Tuesday of every month after the payment run.
A submitter ID is required to exchange HIPAA EDI files.

An 834 transaction file is utilized. A cumulative 834 is sent from SCDHHS to Maximus every month. Maximus then breaks out all the recipients for each MCO and MHN and sends an 834 to each MCO and MHN. So in other words, the monthly 834 sent to each MCO and MHN comes from Maximus. The 834 transcation file layout can be found at:
https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

An 820 transaction file is used. The 820 is sent from SCDHHS.
Refer to the SCDHHS companion guides at:
https://www.scdhhs.gov/resource/electronic-data-interchange-edi

FILES EXCHANGED BETWEEN SCDHHS AND MCOs
Updated: 7/18/2016

DATES OF EXCHANGED FILES SUMMARIZATION

FILES TO SCDHHS FROM MCO:

1. PROVIDER FILE – Is to be sent with encounter submission but is not required
2. TPL FILE – must be submitted by the 8th of every month
3. ENCOUNTER FILE – requested no later than the 25th of the month.
4. WRAP PAYMENT SUMMARY FILE – must be submitted no later than the 25th of the month. Send a blank/empty file if you have no wrap records.
5. CAPITATED PAYMENT FILE – must be submitted no later than the 25th of the month. Send a blank/empty file if you have no capitated records.
6. CAPITATED PAYMENT VOID FILE – is only submitted if you incur a negative net amount for a provider in your Capitated payment file. This file is not required. If you have no capitated voids please do not send a file nor a control file.

FILES TO MCO FROM SCDHHS:

1. PROVIDER FILE – this will be sent 2 to 3 business days after MGC cutoff.
2. CLAIMS HISTORY – this will be sent 2 to 3 days after MGC cutoff and the GAP claims history will be sent around the 5th of the month.
3. MLE FILE – this will be created and sent during the MGC cutoff run. You will also receive a second MLE file on the 1st of every month, which includes members added between cutoff and the end of the month.
4. 834 – this file will be created and sent during MGC cutoff. There is no notification email.
5. EPSDT FILE – this file is sent at the end of every month.
6. CARRIER CODES FILE– this file is sent by the 5th of every month.
7. CONTRACT RATES FILE -- this file is sent by the 5th of every month.
8. FEE SCHEDULE FILE-- this file is sent by the 5th of every month.
9. RECERTIFICATION FILE – this file is sent by the 5th of every month.
10. 820 – This is sent to your HIPAA mailbox Tuesday following MGC cutoff.
11. IMMUNIZATION FILE – this file is sent around the second Monday of every month.
12. DAILY MEMBERSHIP FILE – this file is sent on a daily basis on all weekdays.
13. 277 – this will be sent after your EDI files have been uploaded (except for NCPDP which don't get a compliance 277) and also after your encounter files have processed (277 containing the edits).
14. ENCOUNTER HISTORY FILE and ENCOUNTER VOID HISTORY FILE – these will be sent on or around the 5th of each month.
15. NPI CROSSWALK/JUNCTION FILE – This will be sent daily on all weekdays.

Claims File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	Filler	1	11	11		
3.	Claim-Indicator	1	12	12		'M' – Verified MHN claim – Recipient is member of a MHN on date of service on the claim. This will be the only indicator found in the sure MHN monthly files. Is not valid for MCO files, or history files. 'H' – Verified MCO claim – Recipient is a member of a MCO on the date of service on the claim. Is not valid for MHN files, or history files. 'S' - History Claim – Recipient was a current member of the MCO or MHN at run time. Their claims are provided for information.
4.	ICD-10 INDICATOR	1	13	13	C	VALUE 9 = ICD-9 VALUE 0 = ICD-10
5.	Recipient Pay Category	2	14	15	C	Table 01 – Assistance Pay Category – at time of claim
6.	Filler	1	16	16		
7.	Recipient RSP code1	1	17	17	C	Table 02 – RSP (Recipient Special Program) Codes
8.	Filler	1	18	18		
9.	Recipient RSP code2	1	19	19	C	Table 02 Note: If any of the RSP fields (3-9) = '5'
10.	Filler	1	20	20		then the recipient was in a MHN
11.	Recipient RSP code3	1	21	21	C	Table 02 at the date of service of this claim.
12.	Filler	1	22	22		
13.	Recipient RSP code4	1	23	23	C	Table 02
14.	Filler	1	24	24		
15.	Recipient RSP code5	1	25	25	C	Table 02
16.	Filler	1	26	26		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
17.	Recipient RSP code6	1	27	27	C	Table 02
18.	Filler	1	28	28		
19.	Recipient County	2	29	30	C	Table 03 - County Codes - residence county at time of claim
20.	Filler	1	31	31		
21.	Recipient Qualifying Category	2	32	33	C	Table 04 - Qualifying Category – at time of claim
22.	Filler	1	34	34		
23.	Recipient Date of Birth	6	35	40	C	YYMMDD
24.	Filler	1	41	41		
25.	Recipient Sex	1	42	42	C	Table 12 – Gender
26.	Filler	1	43	43		
27.	Claim Control #	16	44	59	C	
28.	Filler	1	60	60		
29.	Claim Type	1	61	61	C	see table 5 – Claim Type
30.	Filler	1	62	62		
31.	Type of Bill	1	63	63	C	M=Medicaid, X=Crossover
32.	Filler	1	64	64		
33.	From Date of Service	6	65	70	C	YYMMDD Claim Type Z: Admit Date Claim Type J: Premium Date Claim Type G: First DOS = From All others: Date of Service=FROM
34.	Filler	1	71	71		
35.	To Date of Service	6	72	77	C	YYMMDD Claim Type Z: Discharge Date = TO Claim Type J: Effective Date of any change Claim Type G: First DOS = TO All others: Date of Service=TO
36.	Filler	1	78	78		
37.	Date Paid	6	79	84	C	YYMMDD
38.	Filler	1	85	85		
39.	Paid Amount	10	86	95	N	9999999.99 Claim Type D,Z,J,G: Total Paid – Claim All others: Total Paid – Line

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
40.	Filler	1	96	96		
41.	Charged Amount	10	97	106	N	9999999.99 Claim Type D,Z,J,G: Total Charged – Claim All others: Total Charged for Line
42.	Filler	1	107	107		
43.	Amt received - other (TPL)	10	108	117	N	9999999.99 Claim Type G (Nursing Home): Patient income applied to bill. All others claim types – Any other amt received. CLAIM Level field, not line i.e. for HIC & Dental, use only 1 per claim
44.	Filler	1	118	118		
45.	Clm Copayment Amount	8	119	126	N	99999.99 A(HIC), (B)Dental - Line Level D(Drug), (Z) UB92 - Claim Level
46.	Filler	1	127	127		
47.	Line number	2	128	129	C	A (HIC) B (Dental) - Line number D - Medically necessary (field 1) Values: Y=YES, N or Blank or zero = NO All others: not used, will be 01
48.	Filler	1	130	130		
49.	Payment Message Indicator	1	131	131	C	Table 16 – Payment Messages HIC – Payment Message indicator (determines how surgical claim is paid. DRUG – Brand name medically necessary code DENTAL – Oral surgery indicator UB92 - Reimbursement Type
50.	Filler	1	132	132		
51.	Service Code	11	133	143	C	A (HIC), B(DENTAL) – Procedure Subfile & Code (first 6 bytes) Subfile = Table 6, Procedure Code – File 1 D (DRUG) - NDC code (all 11 bytes) - File 6 – NDC Drug Code Z (UB92) – attending MD UPIN if present
52.	Filler	1	144	144		
53.	Proc code modifier	3	145	147	C	A (HIC), B (DENT) – Procedure Code Modifier -Table 7 Z (UB92) - Type of Bill - Table7Z

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
54.	Filler	1	148	148		
55.	Place of service	2	149	150	C	A (HIC) - 2 byte place of service Table 8 B (DENT) - 1 byte place of service Table 8 Z (UB92) - Patient Status Table 8Z All others – not used
56.	Filler	1	151	151		
57.	Units	4	152	155	N	A (HIC), B (DENT) - units D (DRUG) – Quantity Z (UB92) - Inpatient - Covered Days G (NH) - Total days All Others – not used
58.	Filler	1	156	156		
59.	Diagnosis code Primary	6	157	162	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) - Therapeutic Class if present – Table 19
60.	Filler	1	163	163		
61.	Diagnosis code Second	6	164	169	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) – Generic Class if present
62.	Filler	1	170	170		
63.	Diagnosis code Admit	6	171	176	C	Z (UB92) only - Admit diagnosis: File #2 – Diagnosis Codes
64.	Filler	1	177	177		
65.	Funding code-1	2	178	179	C	File # 3 Fund Codes – valid for all claim types
66.	Filler	1	180	180		
67.	Funding code-2	2	181	182	C	File # 3 Fund Codes - valid only for hospital claims
68.	Filler	1	183	183		
69.	Funding code-3	2	184	185	C	File # 3 Fund Codes - valid only for hospital claims
70.	Filler	1	186	186		
71.	Paid Provider #	6	187	192	C	Provider Paid for the Services File # 4 and # 8 – Provider and Provider Group Affiliations

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
72.	Filler	1	193	193		
73.	Paid Provider Type	2	194	195	C	Table # 9 – Provider Types
74.	Filler	1	196	196		
75.	Paid Provider Specialty	2	197	198	C	Table # 10 – Provider Specialty
76.	Filler	1	199	199		
77.	Servicing Provider #	6	200	205		A (HIC) and B (DENT) – Provider of services All others – same as Paid Provider File # 4 and # 8 – Provider and Provider Group Affiliations
78.	Filler	1	206	206		
79.	Servicing Prov Type	2	207	208	C	A (HIC) and B (DENT): Provider of services All others – same as Paid Provider Table # 9 – Provider Types
80.	Filler	1	209	209		
81.	Servicing Prov Specialty	2	210	211	C	For A (HIC) and B (DENT) – provider of services UB92, BIO – Category of Service of Paid Provider – Table 20 All others – same as Paid Provider Table # 10 – Provider Specialty
82.	Filler	1	212	212		
83.	Prescriber ID	6	213	218	C	Prescriber Medicaid # f present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use.
84.	Filler	1	219	219		
85.	Prescriber ID-Type	2	220	221	C	Prescriber Provider Type if present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use.
86.	Filler	1	222	222		
87.	Prescriber ID-SSN	9	223	231		Prescriber SSN if present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use Note:
88.	Filler	1	232	232	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
89.	Prescriber ID-NAPB	7	233	239	C	Prescriber NABP if present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use Note:
90.	Filler	1	240	240		
91.	Refill # (blank if orig)	2	241	242	C	Blank or zeroes if original RX, otherwise # refills
92.	Filler	1	243	243		
93.	Days Supply	3	244	246	N	
94.	Filler	1	247	247		
95.	DRG	3	248	250	C	File # 6 – DRG Codes
96.	Filler	1	251	251		
97.	Outpt Visit Type	1	252	252	C	E=emergency room , Table # 11 Outpatient visit codes
98.	Filler	1	253	253		
99.	ICD9 Surgical Code 1	6	254	259	C	File # 7, Surgical Codes
100.	Filler	1	260	260		
101.	ICD9 Surgical Code 2	6	261	266	C	File # 7, Surgical Codes
102.	Filler	1	267	267		
103.	ER Revenue Code	3	268	270	C	ER Revenue code. N/A unless field #49 is equal to "E" (i.e. the claim is an ER claim)
104.	Filler	1	271	271		
105.	Provider Own Reference #	15	272	286	C	A (HIC) B (DENT) G (NH) – Provider own reference D (DRUG) – Prescription number Z (UB92) – Medical Records number
106.	Filler	1	287	287		
107.	Paid Provider Ownership Code	3	288	290	C	Table #18 – Provider Ownership
108.	Filler	1	291	291		
109.	Prescriber Number	10	292	301	C	Match to file on DHHS Drug Website # assigned to a physician which is used to identify the prescriber.
110.	Filler	1	302	302		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
111.	HIC- Authorization Number	8	303	310	C	Prior authorization # for Claim Type A
112.	Filler	1	311	311		
113.	Provider County	2	312	313	C	Provider county Table 3 – County codes
114.	Filler	1	314	314		
115.	Prior Authorization Number 1	13	315	327	C	Prior Authorization # for Claim Type B
116.	Filler	1	328	328		
117.	Prior Authorization Number 2	7	329	335	C	Prior Authorization number 2
118.	Filler	1	336	336		
119.	MHN/MCO Provider number	6	337	342	C	For sure claims (PCCM indicator = M or H) this is the MHN or MCO the recipient is a member of at the date of service. For history claims (PCCM indicator = S) this is the MHN or MCO the recipient is a current member of.
120.	Filler	1	343	343		
121.	Check Number	7	344	350	C	
122.	Filler	1	351	351		
123.	Gatekeeper Physician	6	352	357	C	Valid for MHN sure claims only (PCCM indicator = M) – This is the physician number of the gatekeeper at the date of service of the claim.
124.	Filler	3	358	360	C	Reserved for future use
125.	ICD-10 Primary Diagnosis	7	361	367	C	ICD-10 Code
126.	ICD-10 Secondary Diagnosis	7	368	374	C	ICD-10 Code
127.	ICD-10 Admitting Diagnosis	7	375	381	C	ICD-10 Code
128.	ICD-10 Surgery Code 1	7	382	388	C	ICD-10 Code
129.	ICD-10 Surgery Code 2	7	389	395	C	ICD-10 Code
130.	Filler	20	396	415	C	

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is ‘implied’ and will not be included.

C = Character – All character fields are left justified and space filled to the right

Unless otherwise specified there will be no signed fields

DHEC Immunization File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	Medicaid ID	10	1	10	N	Recipient Medicaid ID
2.	Insurance Co ID	20	11	30	C	Not used – Value Spaces
3.	Last Name	30	31	60	C	
4.	First Name	20	61	80	C	
5.	Date Of Birth	8	81	88	C	MASK: YYYYMMDD
6.	Date of Shot	8	89	96	C	MASK: YYYYMMDD
7.	Shot Name	30	97	126	C	Name of the shot. Beginning of the field is the CPT code.
8.	Filler	24	127	150		Value Spaces
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0044297.
The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

This is a special interface with DHEC. It is to provide a file to DHEC, in HHCD011 named DHEC.IMMUN, which will pass against their files and return immunization information.
The returned file will be passed to Thomson. This is a job which will pick up the DHEC.IMMUN.IN file in HHCD011 and copy it to HHSCDR3 named DSU.DHEC.IMMUN.IN.
This file may eventually need to be transferred to ORS. As of 11/13/09 no decision on this. If it is decided then the file would need to be copied to HHCD006 and named DHEC.IMMUN.IN.

MCO Member File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	MLE-RECORD-TYPE	1	1	1	C	Internal, H=HMO, P=PEP, C=MHN, ? = Other
2.	MLE-CODE	1	2	2	C	Status in Managed Care: A – AUTO ENROLLED R - RETROACTIVE N - NEW P – PREVIOUSLY ENROLLED WITH SAME PHYSICIAN C - CONTINUING D – DISENROLLED M – MATERNITY KICKER
3.	MLE-PROV-NO	6	3	8	C	Physician recipient is enrolled with.
4.	MLE-PROV-NAME	26	9	34	C	Provider Name
5.	MLE-CAREOF	26	35	60	C	Provider Address
6.	MLE-STREET	26	61	86	C	Provider Street
7.	MLE-CITY	20	87	106	C	City
8.	MLE-STATE	2	107	108	C	State
9.	MLE-ZIP	9	109	117	C	Zip code + 4
10.	MLE-RECIP-NO	10	118	127	C	Recipient identifying Medicaid number.
11.	MLE-RECIP-LAST-NAME	17	128	144	C	Recipient Last name
12.	MLE-RECIP-FIRST-NAME	14	145	158	C	Recipient First name
13.	MLE-RECIP-MI	1	159	159	C	Recipient Middle initial
14.	MLE-ADDR-CARE-OF	25	160	184	C	Recipient address
15.	MLE-ADDR-STREET	25	185	209	C	Street
16.	MLE-ADDR-CITY	23	210	232	C	City
17.	MLE-ADDR-STATE	2	233	234	C	State
18.	MLE-ADDR-ZIP	9	235	243	C	Zip code + 4
19.	MLE-ADDR-AREA-CODE	3	244	246	C	Recipient phone number Area code
20.	MLE-ADDR-PHONE	7	247	253	C	Recipient phone number
21.	MLE-COUNTY	2	254	255	C	Recipient county where eligible
22.	MLE-RECIP-AGE	3	256	258	N	Recipient Age
23.	MLE-AGE-SW	1	259	259	C	Values:

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						'Y' = Year 'M' = Month '<' = Less than 1 month 'U' = Unknown
24.	MLE-RECIP-SEX	1	260	260	C	Values: '1' = Male '2'= Female '3' = Unknown
25.	MLE-RECIP-PAY-CAT	2	261	262	C	Recipient category of eligibility – see Table 01 for values
26.	MLE-RECIP-DOB.	8	263	270	C	Recipient date of birth Mask: CCYYMMDD
27.	MLE-ENROLL-DATE	6	271	276	C	MCO Enrollment Date Mask: YYMMDD
28.	MLE-DISENROLL-DATE	6	277	282	C	MCO Disenrollment Date Mask: YYMMDD
29.	MLE-DISENROLL-REASON	2	283	284	C	Reason Code for Disenrollment: 01 - NO LONGER IN MCO PROGRAM 02 - TRANSFERRED TO ANOTHER MANAGED CARE PROVIDER 03 - MEDICAID ELIGIBILITY TERMINATED 04 - HAS MEDICARE OR IS >= 65 YEARS OF AGE 05 - CHANGE TO NON MEDICAID PAYMENT CATEGORY 06 - MANAGED CARE PROVIDER TERMINATED 07 - OCWI (PEP AND PAYMENT CATEGORY 87) 08 - RECIPIENT HAS TPL HMO POLICY
30.	MLE-PR-KEY	3	285	287	C	Premium Rate Category
31.	MLE-PREMIUM-RATE	9	288	296	N	Amount of Premium paid Mask: S9(7)v99
32.	MLE-PREM-DATE.	6	297	302	C	Month for which the premium is paid. Mask: CCYYMM

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
33.	MLE-MENTAL-HEALTH-ARRAY	3	303	305	C	Obsolete
34.	MLE-PREFERRED-PHYS	25	306	330	C	Recipient's preferred provider
35.	MLE-REVIEW-DATE-CCYYMMDD.	8	331	338	C	Date recipient will be reviewed for eligibility and/or managed care enrollment. Mask: CCYYMMDD
36.	PREGNANCY-INDICATOR	1	339	339	C	Pregnancy indicator Values: 'Y' = Yes ' ' = No
37.	MLE-SSN	9	340	348	C	Member's social security number
38.	*TPL-NBR-POLICIES*	*2*	*349*	*350*	C	**Number of TPL policies**
39.	**TPL INFORMATION below REPEATS 10 TIMES IF APPLICABLE This occurs only 5 times on the 834**	**4140**	351	4490		
40.	**POLICY-CARRIER-NAME**	50	351	400	C	Policy carrier name
41.	*POLICY-NUMBER*	25	401	425	C	Policy number
42.	*CARRIER-CODE*	5	426	430	C	Code to signify a carrier
43.	*POLICY- RECIP-EFFECTIVE DATE*	8	431	438	C	Recipient policy effective date Mask: CCYYMMDD

44.	*POLICY-RECIP-LAST UPDATE*	6	439	444	C	Recipient policy last update Mask: YYMMDD
45.	*POLICY-RECIP-OPEN DATE*	8	445	452	C	Recipient policy open date Mask: CCYYMMDD
46.	*POLICY-RECIP-LAPSE DATE*	8	453	460	C	Recipient lapse date policy Mask: CCYYMMDD
47.	*POLICY-RECIP-PREG-COV-IND*	1	461	461	C	Pregnancy coverage indicator
48.	*POLICY-TYPE*	2	462	463	C	Type of policy-health or casualty
49.	*POLICY-GROUP-NO*	20	464	483	C	Policy group number
50.	*POLICY-GROUP-NAME*	50	484	533	C	Policy group name
51.	*POLICY-GROUP-ATTN*	50	534	583	C	Policy group attention
52.	*POLICY-GROUP-ADDRESS*	50	584	633	C	Policy group address
53.	*POL-GRP-CITY*	39	634	672	C	Policy group city
54.	*POL-GRP-STATE*	2	673	674	C	Policy group state
55.	*POL-GRP-ZIP*	9	675	683	C	Policy group zip code + 4
56.	*POL-POST-PAYREC-IND*	1	684	684	C	Values: ‘0’ = cost avoid ‘1’ = no cost avoid
57.	*POLICY-INSURED-LAST NAME*	17	685	701	C	Insured last name
58.	*POLICY-INSURED-FIRST NAME*	14	702	715	C	Insured first name
59.	*POLICY-INSURED-MI-NAME*	1	716	716	C	Insured middle Initial
60.	*POLICY--SOURCE-CODE*	1	717	717	C	Source of info about policy (ie. champus, highway)
61.	*POLICY--LETTER-IND*	1	718	718	C	If present, pass group address info
62.	*POL-EFFECTIVE-DATE*	8	719	726	C	Effective date of policy Mask: CCYYMMDD
63.	*POL-OPEN-DATE*	8	727	734	C	First stored date Mask: CCYYMMDD
64.	*POL-COVER- IND-ARRAY*	30	735	764	C	Occurs 30 Times 1 BYTE FIELDS of What policy will cover

						Values: A = HOSP-INPAT B = HOSP-OUT C = SURGERY D = ANESTHESIA F = DOCT-VISIT G = DIAG-TEST H = C/A-DRUG I = RETRO-DRUG J = PHYS-THRPY K = EYE-EXAM L = GLASSES M = PSYCH-IN N = PSYCH P = HOME-CARE Q = DIALYSIS R = AMBULANCE S = DME U = NH-SKILLED V = NH-INTER X = ORAL-SURG Y = DENTAL
65.	*RECIPIENT-RACE*	2	4491	4492	C	Race code - Reference Table 13
66.	*RECIPIENT-LANGUAGE*	1	4493	4493	C	Language code -Reference Table 21
67.	*RECIPIENT-FAMILY--NUM*	8	4494	4501	C	Family Number
68.	*NEWBORN-RECIPIENT-ID*	10	4502	4511	C	Newborn Medicaid ID
69.	PREMIUM-AGE	3	4512	4514	N	Recipient Age For Premium Calculations
70.	*PREMIUM-AGE-INDICATOR*	1	4515	4515	C	Values: 'Y' = Year 'M' = Month
71.	*FILLER*	85	4516	4600	C	Filler

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297.
The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

Enrollment Reason Codes Used by Enrollment Broker

Code	Description
650	AutoEnrollment
651	Member Choice
652	Plan Choice
654	Reinstatement AutoAssign
656	Newborn AutoEnrollment
657	Member For Cause Transfer
660	Poor Quality of Care
661	Retro-Reinstatement AutoAssign
891	Health Plan Transfer
892	Health Plan Transfer
899	Mass Transfer

Disenrollment Reason Codes Used by Enrollment Broker

Code	Description
03	Member Ineligible for Medicaid
04	Member Eligible for Medicare
05	Member Pay Cat Inconsistent With Managed Care
06	Managed Care Provider Terminated
08	Member Has Private HMO Coverage
10	Provider No Longer Participates In PCCM
30	Moved Out of Plan Service Area
31	Got Poor Quality Care
34	Lack of Access to Services Covered Under the Contract
35	Doctor Not Part of Network
36	Lack of Access to Providers Experienced With Member's Health Care Needs
37	Entering A Waiver Program
38	Entering Hospice
39	Not Able To Get The Medicines I Was Able To Get In Regular Medicaid
40	Entering Nursing Home
41	Other (Requires Additional Note on Exact Reason)
53	Didn't Realize What I was Signing Up For
60	Member Died
61	Member Is Incarcerated
65	Member No Longer Meets Criteria to Participate In Managed Care Program
66	Member Fails to Follow the Rules of the Plan
70	Member Placed Out of Home
71	Plan Initiated PCP Transfer
75	Pharmacy Not Part of Network
83	Want to be in Plan with Family Members
84	Plan Doesn't Offer Coordinated Services Member Needs
85	Health Plan Referral Policy is unfavorable to Member
98	Mass Transfer

Provider File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	HMO-MEDICAID-NUM	6	1	6	C	Managed care plan Medicaid number
2.	PROVIDER-ID-NUMBER	6	7	12	C	Identifies a provider or group provider who is not enrolled as a Medicaid provider. The 1st byte of the number must be the symbol assigned that will identify the MCO on our database. You must use a new, unique ID for each provider. If a provider has several different specialties, you must have a new, unique ID for each specialty. DO NOT USE AN ID MORE THAN ONCE.
3.	PROVIDER-NAME	26	13	38	C	Non-Medicaid Provider's Name
4.	PROVIDER-CAREOF	26	39	64	C	Provider address line 1
5.	PROVIDER- STREET	26	65	90	C	
6.	PROVIDER-CITY	20	91	110	C	
7.	PROVIDER-STATE	2	111	112	C	
8.	PROVIDER-ZIP	9	113	121	C	
9.	PROVIDER-COUNTY	12	122	133	C	County Name
10.	PROVIDER-EIN-NUM	10	134	143	C	Provider identification number(tax ID)
11.	PROVIDER-SSN-NUM	9	144	152	C	
12.	PHARMACY-PERMIT-NUM	10	153	162	C	Pharmacy permit number -- DEA Number
13.	PROVIDER-TYPE	2	163	164	C	Refer to Table 09 for provider types
14.	PROVIDER-SPECIALTY	2	165	166	C	Refer to table for provider specialties
15.	PROVIDER-CATEG-SERV	2	167	168	C	Refer to table for categories of service
16.	PROVIDER-LICENSE-NUMBER	10	169	178	C	SC state license number
17.	PROVIDER-NPI	10	179	188	C	NPI for non-par providers
18.	PROVIDER-PHONE-NUMBER	10	189	198	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
19.	FILLER	2	199	200	C	
20.						
21.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

Output Record For Provider File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	PROVIDER-ID-NUMBER	6	1	6	C	Medicaid provider number
2.	PROVIDER-NAME	26	7	32	C	
3.	PROVIDER-CAREOF	26	33	58	C	Provider address line 1
4.	PROVIDER- STREET	26	59	84	C	
5.	PROVIDER-CITY	20	85	104	C	
6.	PROVIDER-STATE	2	105	106	C	
7.	PROVIDER-ZIP	9	107	115	C	
8.	PROVIDER-PHONE-NUMBER	10	116	125	C	
9.	PROVIDER-COUNTY	12	126	137	C	Refer to table 03 for county codes
10.	PROVIDER-TYPE	2	138	139	C	Refer to table 09 for provider types
11.	PROVIDER-SPECIALTY	2	140	141	C	Refer to table 10 for provider specialties
12.	PROV-PRICING-SPECIALTY	2	142	143	C	
13.	PROVIDIER-NPI	10	144	153	C	
14.	FILLER	38	154	191	C	
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						
26.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297.
The decimal is ‘implied’ and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

Redetermination File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	REV-FAMILY –NUMBER	8	1	8	C	Recipient identifying family number.
2.	Filler	1	9	9		
3.	REV-RECIP-NO	10	10	19	C	Recipient identifying Medicaid number.
4.	Filler	1	20	20		
5.	REV-RECIP-NAME	20	21	40	C	Recipient name, Last,First, Middle Initial
6.	Filler	1	41	41		
7.	REV-ADDR-STREET	25	42	66	C	
8.	Filler	1	67	67		
9.	REV-ADDR-CITY	20	68	87	C	
10.	Filler	1	88	88		
11.	REV-ADDR-STATE	2	89	90	C	
12.	Filler	1	91	91		
13.	REV-ADDR-ZIP	5	92	96	C	
14.	Filler	1	97	97		
15.	REV-ADDR-PHONE	15	98	112	C	
16.	Filler	1	113	113		
17.	REV-REVIEW-DATE	10	114	123	N	CCYY-MM-DD
18.	Filler	1	124	124		
19.	REV-REVIEW-MAILED	10	125	134	N	CCYY-MM-DD
20.	Filler	1	135	135		
21.	REV-PROVIDER-NO	6	136	141	C	
22.	Filler	1	142	142		
23.	REV-BOARD-PROV-NO	6	143	148	C	Applicable for medical home programs only
24.	Filler	1	149	149		
25.	REV-PAYEE-NAME	25	150	174	C	Name of payee for family
26.	Filler	1	175	175		
27.	REV-PAYEE-TYPE	3	176	178	C	Payee Type: See Note 1 below.
28.	Filler	1	179	179		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
29.	REV-RECIP-PAY-CAT	2	180	181	C	Pay Categories: See Note 2 below.
30.	Filler	1	182	182		
31.	COUNTY-WORKER-FIRST-NAME	17	183	199	C	
32.	Filler	1	200	200		
33.	COUNTY-WORKER-LAST-NAME	26	201	226	C	
34.	Filler	1	227	227		
35.	COUNTY-WORKER-PHONE	10	228	237	C	
36.	Filler	1	238	238		
37.	COUNTY-WORKER-PHONE-EXTENSION	4	239	242	C	
38.	Filler	1	243	243	C	
39.	HOUSEHOLD NUMBER	9	244	252	C	Ties households together.
40.	Filler	48	253	300		

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left EX: 5 bytes 123 will appear as 00123
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields
Logic for inclusion in this file is as follows:

```
WHERE  BG.BG_CDE_STATUS = 'A'
       AND BG.BG_CDE_ACTION = 'R'
       AND ((BG.BG_DTE_FORM_MAILED <= CURRENT DATE - 30 DAYS)
       OR (BG.BG_DTE_FORM_MAILED IS NULL))
       AND BG.BG_DTE_FORM_RECD IS NULL
       AND BG.BG_NUM_PYMT_CATEGORY IN ('12','15','16','17','18',
         '19','32','40','57','59','71','88')
      AND BG.BG_UID_WORKER_ID = WKR.WKR_UID_WORKER_ID
      AND BG.BG_NUM_BUDGET_GROUP_ID = HB.HBJ_NUM_BUDGET_GROUP_ID
      AND BG.BG_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID
      AND MEH.MEH_NUM_MEMBER_ID = BMJ.BMJ_NUM_MEMBER_ID
      AND MEH.MEH_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID
      AND MEH.MEH_DTE_INELIG IS NULL
      AND WKR.WKR_CDE_COUNTY = LOC.LOC_CDE_COUNTY
      AND WKR.WKR_CDE_LOCATION = LOC.LOC_CDE_LOCATION
```

Note 1: Payee Types for Field 27.
SEL SELF OR AFDC PAYEE
GDN LEGAL GUARDIAN
REL OTHER RELATIVE
AGY SOCIAL AGENCY
PPP PROTECTIVE PAYEE
REP REPRESENTATIVE PAYEE
FOS INDICATES FOSTER CHILD
SPO SPOUSE
INP LEGALLY INCOMPETENT, NO REPRESENT

Note 1: Payment Categories for Field 29.
10 MAO (NURSING HOMES)

11 MAO (EXTENDED TRANSITIONAL)
12 OCWI (INFANTS UP TO AGE 1)
13 MAO (FOSTER CARE/SUBSIDIZED ADOPTION)
14 MAO (GENERAL HOSPITAL)
15 MAO (CLTC)
16 PASS-ALONG ELIGIBLES
17 EARLY WIDOWS/WIDOWERS
18 DISABLED WIDOWS/WIDOWERS
19 DISABLED ADULT CHILD
20 PASS ALONG CHILDREN
30 AFDC (FAMILY INDEPENDENCE)
31 TITLE IV-E FOSTER CARE
32 AGED, BLIND, DISABLED
33 ABD NURSING HOME
40 WORKING DISABLED
41 MEDICAID REINSTATEMENT
48 S2 SLMB
49 S3 SLMB
50 QUALIFIED WORKING DISABLED (QWDI)
51 TITLE IV-E ADOPTION ASSISTANCE
52 SLMB (SPF LOW INC MEDCARE BENEFICIAR)
53 NOT CURRENTLY BEING USED
54 SSI NURSING HOMES
55 FAMILY PLANNING
56 COSY/ISCEDC
57 KATIE BECKETT CHILDREN - TEFRA
58 FI-MAO (TEMP ASSIST FOR NEEDY)
59 LOW INCOME FAMILIES
60 REGULAR FOSTER CARE
68 FI-MAO WORK SUPPLEMENTATION
70 REFUGEE ENTRANT
71 BREAST AND CERVICAL CANCER
80 SSI

81 SSI WITH ESSENTIAL SPOUSE
85 OPTIONAL SUPPLMENT
86 SUPPLEMENT & SSI
87 OCWI (PREGNANT)
88 OCWI (CHILD UP TO 19)
90 MEDICARE BENE(QMB)
91 RIBICOFF CHILDREN
92 ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE

Appendix B

Medicaid Management Information System (MMIS) Tables

TABLE 1209
PLACE OF SERVICE, MMIS Table # T1209
Last Updated 06/25/08

1 INPATIENT HOSPITAL
2 OUTPATIENT HOSPITAL
3 OFFICE
4 HOME
5 DAY CARE FACILITY (PSY)
6 NIGHT CARE FACILITY (PSY)
7 NURSING HOME (NH)
8 SKILLED NURSING HOME FACILITY (SNF)
9 AMBULANCE
0 OTHER LOCATION
A INDEPENDENT LABORATORY
B AMBULATORY SURGICAL CENTER (ASC)
C RESIDENTIAL TREATMENT CENTER (RTC)
D SPECIALIZED TREATMENT CENTER (STF)
E COMPREHENSIVE OUTPATIENT REHAB FACILITY (COR)
F INDEPENDENT KIDNEY DISEASE TREATMENT CENTER (KDC)
G INDIVIDUAL (TRANSPORTATION)
H RESPITE CARE FACILITY

Type	#	Table Name
Table	01	Assistance Payment Categories
Table	02	RSP Codes
Table	03	County codes and Names
Table	04	Qualifying Category
Table	05	Claim Type
Table	06	Procedure Code Subfile
Table	07	Procedure Code Modifiers
Table	07Z	Modifier values for UB92
Table	08	Place of Service
Table	08Z	UB92 Patient Status
Table	09	Provider Types
Table	10	Provider Speciality
Table	11	Emergency Room Indicator
Table	12	Recipient Gender
Table	13	Recipient Race
Table	14	Recipient Living Arrangement
Table	15	Recipient Facility Type
Table	16	Payment Message-Drug Class-Reimbursement Type
Table	17	Provider Status
Table	18	Provider Ownership
Table	19	Drug Therapeutic Class
Table	20	Category of Service
Table	21	Language Codes
Table	22	834 Compliant Race Code

		File Names:
File	1	CPT-4 Proc codes
File	2	ICD-9 Diagnosis codes
File	3	Funding Codes
File	4	Provider File
File	5	NDC Code File
File	6	DRG Code File
File	7	ICD-9 Surgical Codes
File	8	Provider Member File

TABLE 1 Assistance Payment Category

Last updated in MMIS 05/23/08,
Last update in this directory 06/26/08

10 MAO (NURSING HOMES)
11 MAO (EXTENDED TRANSITIONAL)
12 OCWI (INFANTS UP TO AGE 1)
13 MAO (FOSTER CARE/SUBSIDIZED ADOPTION)
14 MAO (GENERAL HOSPITAL)
15 MAO (CLTC)
16 PASS-ALONG ELIGIBLES
30 AFDC (FAMILY INDEPENDENCE)
31 TITLE IV-E FOSTER CARE
32 AGED, BLIND, DISABLED
40 WORKING DISABLED
41 MEDICAID REINSTATEMENT
50 QUALIFIED WORKING DISABLED (QWDI)
51 TITLE IV-E ADOPTION ASSISTANCE
52 SLMB (SPF LOW INC MEDCARE BENEFICIAR)
53 NOT CURRENTLY BEING USED
54 SSI NURSING HOMES
55 FAMILY PLANNING
56 COSY/ISCEDC
57 KATIE BECKETT CHILDREN - TEFRA
58 FAMILY INDEPENDENCE SANCTIONED
59 LOW INCOME FAMILIES
60 REGULAR FOSTER CARE
70 REFUGEE ENTRANT
71 BREAST AND CERVICAL CANCER
80 SSI
81 SSI WITH ESSENTIAL SPOUSE
85 OPTIONAL SUPPLEMENT
86 OPTIONAL SUPPLEMENT & SSI
87 OCWI (PREGNANT WOMEN)
88 OCWI (CHILDREN UP TO AGE 19) PHC
90 QUALIFIED MEDICARE BENEF (QMB)
91 RIBICOFF CHILDREN
92 ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE
99 HEALTHY CONNECTION KIDS (SCHIP); NOT MEDICAID ELIGIBLE

TABLE 2
RSP Codes
Updated 01/20/06 - Old - Prior to 1/4/2011.

ALVG	Q	L	CLTC Assisted Living Waiver
ASTH	Y	-	Non-PEP Asthma
CHPC	H	C	CLTC Children's PCA
CLTC	A	E	CLTC Elderly Disabled
COSY	B	6	Cosy Project - Beaufort County
DMRE	M	5	DMR Waiver/Established
DMRN	L	5	DMR Waiver/New
HIVA	F	B	CLTC HIV AIDS
HREX	C	-	High Risk/Exempt
HRHI	E	-	High Risk/HI
HRHT	O	-	High Risk High/Transitions
HRLO	D	-	High Risk/LO
HSCE	S	H	Head and Spinal Cord/Established
HSCN	T	H	Head and Spinal Cord/New
IPCS	Z	-	Integrated Personal Care Services
ISED	I	6	Interagency Sys. of Care for Emot. Dist. Ch.
LEAD	2	-	Non-PEP Lead
MCCM		5 -	Primary Care Case Management (Medical Care Home)
MCFC	U	9	Medically Fragile Children's Program
MCHA	-	-	SCHAP
MCHM		N 8	HMO
MCHS	K	7	Hospice
MCNF	W	9	Medically Fragile Non-Foster Care
MCPA	X	-	PEP Asthma
MCPC	Z	-	Integrated Personal Care Services
MCPL	1	-	PEP Lead
MCPP	G	-	Physicians Enhanced Program
MCRH	R	R	Rural Behavioral Health Services
MCSP			State Pharmacy Assistance Program
NHTR	4	N	Nursing Home Transition
PSCA	J	P	Palmetto Senior Care
SCCH	3	S	SC Choice
VENT	V	V	CLTC Ventilator Waiver
WAHS		P -	Waiver Healthy Start

TABLE 2
RSP Codes
Updated 01/04/2011

AUTW	8	A	Autism Waiver	
CHPC	H	C	CLTC Children's PCA	
CLTC	A	E	CLTC Elderly Disabled	
COSY	B	6	Cosy Project - Beaufort County	
CSWE	D	W	Community Supports Waiver - Established	
CSWN	C	W	Community Supports Waiver - New	
DMRE	M	5	DMR Waiver/Established	
DMRN	L	5	DMR Waiver/New	
HIVA	F	B	CLTC HIV AIDS	
HOAD	7	Health Opportunity Account; in deductible pd.		
HOAP		6	Health Opportunity Account; no co pay	
HSCE	S	H	Head and Spinal Cord/Established	
HSCN	T	H	Head and Spinal Cord/New	
ISED	I	6	Interagency Sys. of Care for Emot. Dist. Ch.	
MCCM		5	-	Primary Care Case Management (Medical Care Home)
MCFC	U	9	Medically Fragile Children's Program	
MCHM		N	8	HMO
MCHS	K	7	Hospice	
MCNF	W	9	Medically Fragile Non-Foster Care	
MCPC	Z	-	Integrated Personal Care Services	
MCPP	G	-	Physicians Enhanced Program	
MCSC		J	P	PACE
NHTR	4	N	Nursing Home Transition	
PRTF	9	-	Alternative Psychiatric Residential Treatment Facility	
VENT	V	V	CLTC Ventilator Waiver	
WAHS		P	-	Waiver Healthy Start
WMCC		3	S	Medically Complex Children's Waiver

TABLE 3
County codes and Names- LAST UPDATED 1/20/06

CODE	DESCRIPTION
01	ABBEVILLE
02	AIKEN
03	ALLENDALE
04	ANDERSON
05	BAMBERG
06	BARNWELL
07	BEAUFORT
08	BERKELEY
09	CALHOUN
10	CHARLESTON
11	CHEROKEE
12	CHESTER
13	CHESTERFIELD
14	CLARENDON
15	COLLETON
16	DARLINGTON
17	DILLON
18	DORCHESTER
19	EDGEFIELD
20	FAIRFIELD
21	FLORENCE
22	GEORGETOWN
23	GREENVILLE
24	GREENWOOD
25	HAMPTON
26	HORRY
27	JASPER
28	KERSHAW
29	LANCASTER
30	LAURENS
31	LEE
32	LEXINGTON
33	MCCORMICK
34	MARION
35	MARLBORO
36	NEWBERRY
37	OCONEE
38	ORANGEBURG
39	PICKENS
40	RICHLAND
41	SALUDA
42	SPARTANBURG
43	SUMTER
44	UNION
45	WILLIAMSBURG
46	YORK
47	DHHS
60	GA<25MI
61	GA>25MI
62	NC<25MI
63	NC>25MI
64	OTHER

TABLE 4
Qualifying Category
Last Update 1/20/06

10 AGED
20 BLIND
30 AFDC
31 AFDC-FC
40 GDA
41 PREGNANT WOMEN
50 DISABLED
60 REGULAR FOSTER CARE
70 INDO CHINESE REFUGEES
71 CHILDREN

TABLE 5
Claim/Document Type
Last updated 01/20/06

A HIC/PHYSICIANS
B DENTAL
C MED-TRANSPORTATION
D DRUG
G NURSE-HOME-INV
J BUY-IN/MANAGED CARE PREMIUM PAYMENT
L MEDICARE-A - NOT USED PRESENTLY
M MEDICARE-B - NOT USED PRESENTLY
R MANUAL-XOVER-A - NOT USED PRESENTLY
S MANUAL-XOVER-B - NOT USED PRESENTLY
T EPSDT - NOT USED PRESENTLY
U ADJUSTMENT
Z UB92

Table 6
PROCEDURE CODE SUBFILE
Last Updated 1/20/06

A ADA
B LOCAL CODE
C CPT4
D DSS
E PVT MENTAL
F SC DMH
G ALCHOL/SUB
H MENTAL RET
I SED CHILDR
J AUDIOLOGY
K NURSE
L ANESTH
M PSYCH
N THERAPIST
O OP HOSP
P PHYSICIAN
Q ESRD/CLIN
R DHEC
S AUDIO/CORF
T AMB SURG
U DIABETES
V DR/SB/MFCP
W FP M & CHD
X OPT
Y DME/AM/MIS
Z PHYS ASST
1 E/D
2 VENT
3 HIV/AIDS
4 CHILD PCA
5 SC CHOICE
6 CLTC
7 PSC
8 DMR
9 HASCI

TABLE 7
Procedure Code Modifiers TABLE 1304 IN MMIS
LAST UPDATED IN MMIS: 06/27/07

CODE	DESCRIPTION
0AA	ANES PERSONALLY PERFORMED
0AB	ANES. SVC. EMP. BY ANES.
0AC	HOSP. BASED ANES. SERV
0AD	ANES SUP OWN EMP - OVER 4
0AE	RESIDENT ANES. SERVICES
0AF	ANESTHESIA RISK FACTOR
0AG	ANESTHESIA RISK FACTOR
0AH	CLINICAL PSYCHOLOGIST
0AJ	CLINICAL SOCIAL WORKER
0AK	NURSE PRAC, TEAM MEMBER
0AL	NURSE PRACT NON-RUR TM MEM
0AM	PHYSICIAN, TEAM MEMBER
0AN	PA SERV NOT ASSIST SURG
0AP	REFRACTION NOT PERFORMED
0AR	AMBULANCE RETURN TRIP
0AS	PA,NP,OR CLINICAL NRSE FOR ASST SURG
0AT	ACUTE TREATMENT
0AU	PHYS ASSIST NOT SURG TEAM
0AV	NURSE PRACTICE,NON-TEAM M
0AW	CLIN NURSE SPEC,NON-TEAM
0AY	CLIN NURSE SPEC,TEAM MEM
0BP	RCP INFORMED,ELECTED PURC
0BR	RCP INFORMED,ELECTED RENT
0BU	RCP NOT INFORM PRV OF DEC
0CC	PROC CODE CHANGE
0DD	POWDERED ENTERAL FORMULA
0DE	DIAG SITE TO RES FAC
0DG	DIAG SITE TO HB DIAL FAC
0DH	DIAG SITE TO HOSPITAL
0DJ	DIAG SITE TO NON HB DIAL
0DN	DIAG SITE TO SNF
0DP	DIAG SITE TO PHYS OFFICE
0DR	DIAG SITE TO RESIDENCE
0ED	RES FACILITY TO DIAG SITE
0EE	RES FAC TO RES FAC
0EG	RES FAC TO HB DIAL FAC
0EH	RES FACILITY TO HOSPITAL
0EJ	SUB CL/RES FC-NON HB DIAL
0EM	EMERG RESERVE SUPPLY
0EN	RES FAC TO SNF
0EP	RES FAC TO PHYS OFFICE
0ER	RES FAC TO RESIDENT
0ET	EMERGENCY TREATMNT DENTAL
0EV	EMERGENCY EVACUATION TRANSPORT

0E1 UPPER LEFT, EYELID
0E2 LOWER LEFT, EYELID
0E3 UPPER RIGHT, EYELID
0E4 LOWER RIGHT, EYELID
0FA LEFT HAND, THUMB
0FP FAMILY PLANNING
0F1 LEFT HAND, SECOND DIGIT
0F2 LEFT HAND, THIRD DIGIT
0F3 LEFT HAND, FOURTH DIGIT
0F4 LEFT HAND, FIFTH DIGIT
0F5 RIGHT HAND, THUMB
0F6 RIGHT HAND, SECOND DIGIT
0F7 RIGHT HAND, THIRD DIGIT
0F8 RIGHT HAND, FOURTH DIGIT
0F9 RIGHT HAND, FIFTH DIGIT
0GA WAIVER OF LIAB STMT ON FILE
0GB DISTINCT PROCEDURAL SERVICE
0GC SERV BY RESIDENT W/ TEACHING PHYSICIAN
0GD HOSP BSD DIALYS FAC-DIAL OR THERAP SITE
0GE SERV BY RESIDENT W/O TEACHING PHYSICIAN
0GH DIAGNOSTIC MAMGRAM CNVRT FRM SCRNING
0GJ OPT OUT PHYS OR PRACT EMERG/URGENT SERVICE
0GN PERSONAL SERV BY SPCH/LANG PATH OR OP SP/LG PLAN
0GO PERSONAL SERV BY OCCU THRPT OR OP OCCU THRPT PLAN
0GP PERSONAL SERV BY PHYS THRPT OR OP PHYS THRPT PLAN
0GR HOSP BSD DIALYS FAC-RESIDENCE
0GT VIA INTERACTIVE AUDIO/VIDEO TELE SYSTEMS
0GX SERVICE NOT COVERED BY MEDICARE
0GY ITEM/SVC STATUTORILY EXCL
0G1 MOST RECENT URR READING OF < 60
0G2 MOST RECENT URR READING OF 50 TO 64.9
0G3 MOST RECENT URR READING OF 65 TO 69.9
0G4 MOST RECENT URR READING OF 70 TO 74.9
0G5 MOST RECENT URR READING OF 75 OR >
0G6 ESRD PAT < 6 DIALYSIS SESSIONS PER MO
0G7 PREG RAPE/INCEST/LIFE THR
0G8 MONITOR ANEST CARE/COMPLI
0G9 MONITOR ANEST CARE/CARDIO
0HD HOS TO DIAG SITE
0HE HOS TO RES FAC
0HH HOS TO HOS
0HI HOS TO SITE OF TRANSF
0HJ HOS TO NON-HB BASED DIAL
0HN HOS TO SNF
0HP HOS TO PHYS OFFICE
0HR HOSP TO RESIDENT
0HT ROUND TRIP FOR DIAG TRTMN
0IE SITE OF TRANS TO RES FAC
0IH SITE OF TRANS TO HOS

0IN SITE OF TRANS TO SNF
0JE NON-HB DIAL TO RES FAC
0JH NON-HB DIAL FAC TO HOS
0JN NON-HB DIAL FAC TO SNF
0JP NON-HB DIAL TO PHY OFF
0JR NON-HB DIAL FAC TO RES
0KA ADD ON OPT/ACC FOR WHL CHR
0KB 16 SQUARE INCHES OR LESS
0KC GT 16, LT/EQ TO 48 SQ INCH
0KD GT 48 SQUARE INCHES
0KE 1 OUNCE
0KF 1 LINEAR YARD
0KG DMEPOS COMP BID PROG 1
0KH DMEPOS IN CL PUR/1ST MO RT
0KI DMEPOS 2ND OR 3RD MO RT
0KJ DMEPOS PP/REN, MO 4 - 15
0KK DMEPOS COMP BID 2
0KL ITEM DELIVERED VIA MAIL
0KM REPL FACIAL PROSTHESIS INC NEW
0KN REPL FACIAL PROSTHESIS INC PREV
0KO SINGLE DRUG UNIT DOSE FORMULATION
0KP 1ST DRUG OF A MULTIP DRUG UNIT DOSE FORM
0KQ 2ND/SUBS DRUG OF MULTI DRUG UNT DOSE FRM
0KS GLUCOSE MONITOR SUPPLY RCP NOT ON INSULIN
0KT BEN COMP TO NON-COMP SUP
0KU DMEPOS COMP BID PROG 3
0KX SPECIFIED REQUIREMENT MET
0K0 LOW EXTR PROS FCT LVL 0
0K1 LOW EXTR PROS FCT LVL 1
0K2 LOW EXTR PROS FCT LVL 2
0K3 LOW EXTR PROS FCT LVL 3
0K4 LOWER PROS FCT LVL 4
0LC LEFT CIRCUMFLEX CORONARY ARTERY
0LD LEFT ANTERIOR DESC CORONARY ARTERY
0LL LEASE/RENTAL PURCH PRICE
0LR LABORATORY ROUND TRIP
0LS FDA MON INTRA LENS IMPLAN
0LT LEFT SIDE
0MP MULTY-VISITS/MULTY-RECIPS
0MS 6 MONTH MAINT/SERV FEE
0ND SNF TO DIAG SITE
0NE SNF TO RES FAC
0NG SNF TO HB DIAL FAC
0NH SNF TO HOSP
0NI SNF TO SITE OF TRANSF
0NJ SNF TO NON-HB DIAL FAC
0NN SNF TO ANOTHER SNF
0NP SNF TO PHYS OFFICE
0NR NEW WHEN RENT/SNF TO RES

0NT NO TRANSPORTATION
0NU PURCHASE OF NEW DME
0PD PHYS OFFICE TO DIAG SITE
0PE PHYS OFFICE TO RES FAC
0PG PHY OFF TO HB DIAL FAC
0PH PHYSICIANS OFFICE TO HOSP
0PJ PHY OFF TO NON-HB DIAL FAC
0PL PROGRESS ADDITION LENSES
0PN PHYS OFFICE TO SNF
0PP PHYS OFFICE TO PHYS OFFC
0PR PHYS OFF TO RESIDENCE
0QA FDA INVESTIGATIONAL DEVICE EXEMPTION
0QB PHY SERV IN RURAL HPSA
0QC SING CHANNEL MONITORING
0QD RECORD DIGITAL RECORDER
0QE OXY LESS THAN 1 LTR/MIN
0QF OXY GT 4LPM POST PRESCRIB
0QG OXY GT 4 LPM
0QH ANES SUP OWN EMP - 2
0QI ANES SUP OWN EMP - 3
0QJ MED DIRECTED BY PHY, 2 PROC
0QK MED DIR 2/3/4 ANES PROC
0QL PATIENT PRONOUNCED DEAD AFTER AMB CALLED
0QM PROV OF SERV ARRANGED AMB SERV
0QN PROV OF SERV FURNISHED AMB SERV
0QO ANES SUP OF 3 CONCUR PROC
0QP DOC ON FILE/TEST ORDERED INDIV OR PANEL
0QQ ANES SUP OF 4 CONCUR PROC
0QR REP CLI DIA LAB TST SM DAY SUBS TST VAL
0QS MONITORED ANES CARE
0QT RECORD ANALOG RECORDER
0QU PHY SERV IN URBAN HPSA
0QW CLIA WAIVED TEST
0QX SUPERVISED CRNA
0QY MED DIR OF 1 CRNA BY ANES
0QZ UNSUPERVISED CRNA
0Q1 MYCOSIS OF THE TOENAIL
0Q2 HCFA/ORD DEM PRJ PROC/SER
0Q3 LIVE KIDNEY DONOR
0Q4 PHY QUALIF AS A SER EXEMP
0Q5 SRV BY SUB PHYS RECIPROCAL
0Q6 SRV BY LOCUM TENENS PHYSN
0Q7 ONE CLASS A FINDING
0Q8 TWO CLASS B FINDINGS
0Q9 ONE CLASS B AND TWO CLASS C FINDINGS
0RA FRM PAT RES TO OFFICE
0RC RIGHT CORONARY ARTERY
0RD RES TO DIAG SITE
0RE RESIDENCE TO RES FAC

0RG RES TO HB DIAL FAC
0RH RES TO HOSPITAL
0RI RES TO SITE OF TRANSFER
0RJ RES TO NON-HB DIAL FAC
0RN RES TO SNF
0RP REPL PART/RES TO PHYS OFF
0RR RESIDENCE TO RESIDENCE
0RT RIGHT SIDE
0SA NP SVC W/COLLATORAT PHYS
0SE ACCID T/ACUTE EVENT TO RES/CUST FAC
0SF PRO ORDERED 2ND OPINION
0SG AMB SURG CTR FACILITY SVS
0SH ACCIDENT TO HOSP
0SI SCENE OF ACC TO TRSF SITE
0SP ACCIDENT TO PHYS OFFICE
0TA LEFT FOOT, GREAT TOE
0TC TECHNICAL COMPONENT
0TM TELEMEDICINE EQUIP&PRACT
0T1 LEFT FOOT, SECOND DIGIT
0T2 LEFT FOOT, THIRD DIGIT
0T3 LEFT FOOT, FOURTH DIGIT
0T4 LEFT FOOT, FIFTH DIGIT
0T5 RIGHT FOOT, GREAT TOE
0T6 RIGHT FOOT, SECOND DIGIT
0T7 RIGHT FOOT, THIRD DIGIT
0T8 RIGHT FOOT, FOURTH DIGIT
0T9 RIGHT FOOT, FIFTH DIGIT
0UC UNCLASSIFIED
0UE USED EQUIPMENT
0VP APHAKIC PATIENT
0WJ REPEAT PROF. COMPONENT
0WK MD PERSON. SUP/PERF TEST
0WM NURSE MIDWIFE SERVICE
0W1 1 FINAL FRACTION
0W2 2 FINAL FRACTIONS
0W3 3 TOT OR FINAL FRACTIONS
0W4 4 TOT OR FINAL FRACTIONS
0W5 5 TOT FIN OR INT FRACTION
0XX AMB RES/NH TO MD, TO HOSP
0X1 1 FRACTION REP TOT TRTMNT
0X2 2 FRACTION REP TOT TRTMNT
0YY SECOND SURGICAL OPINION
0ZZ THIRD SURGICAL OPINION
000 NO SPECIFIED MODIFIER
001 WELL CHILD/TREATED TODAY (PEP)
002 WELL CHILD/REFERRED FOR TREATMENT (PEP)
020 MICROSURGERY TECHNIQUES
021 PROLONGED EVAL & MAN SVS
022 UNUSUAL SERVICES

023 UNUSUAL ANESTHESIA
024 UNREL EM SV SAME MD PSTOP
025 SEP EM SV SAME MD/DAY
026 PROFESSIONAL COMPONENT
032 REQ BY THIRD PARTY PAYER
047 SURG PERFORMED ANES SERV
050 BILATERAL PROCEDURES
051 MULTI PROCEDURES
052 REDUCED SERVICES
053 DISCOUNTED PROCEDURE
054 SURGICAL CARE ONLY
055 POSTOP MANAGEMENT ONLY
056 PREOP MANAGEMENT ONLY
057 DECISION FOR SURGERY
058 REL SERV SAME PHY POSTOP
059 DISTINCT PROCEDURAL SERVICE
062 TWO SURGEONS
066 SURGICAL TEAM
073 DISCONT OP/AMB SURG CNTR PROC BEFORE ANESTH
074 DISCONT OP/AMB SURG CNTR PROC AFTER ANESTHH
076 REPEAT PROC BY SAME PHYS
077 REPEAT PROC BY ANOT PHYS
078 RETURN FOR REL PROC PSTOP
079 UNREL PROC SAME MD/POSTOP
080 ASSISTANT SURGEON
081 MINIMUM ASSISTANT SURGERY
082 ASST. SURGERY TEACH. FAC.
090 SPECIMEN SENT TO IND LAB
091 REPEAT CLIN DIAG LAB TEST
099 MULTIPLE MODIFIERS

Table 7Z
Procedure Modifier
Updated 1/20/06
Values for UB92:

Field 1:

UZO-FACIL-TYPE

1 HOSPITAL
2 SKILLED NURSING
3 HOME HEALTH
4 CHRISTIAN SCIENCE HOSPITAL
5 CHRISTIAN SCIENCE EXTENDED CARE
6 INTERMEDIATE CARE
7 CLINICS
8 SPECIAL FACILITY

Field 2:
UZO-BILL-CLASS

***** VALUE EXCEPT FOR CLINICS & SPECIAL FACILITIES**
- **1 INPATIENT INCLUDING MEDICARE PART A**
- **2 INPATIENT MEDICARE PART B ONLY**
- **3 OUTPATIENT**
- **4 OTHER**
- **5 INTERMEDIATE CARE LEVEL I**
- **6 INTERMEDIATE CARE LEVEL II**
- **7 INTERMEDIATE CARE LEVEL III**
- **8 SWING BEDS**

***** VALUE FOR CLINICS ONLY**
- **1 RURAL HEALTH**
- **2 HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS**
- **3 FREE STANDING**
- **4 OUTPATIENT REHABILITATION FACILITY (ORF)**
- **5 COMPREHENSIVE OUTPATIENT REHAB FACILITY (CORF)**

***** VALUE FOR SPECIAL FACILITIES ONLY**
- **1 HOSPICE (NON-HOSPITAL BASED)**
- **2 HOSPICE (HOSPITAL BASED)**
- **3 AMBULATORY SURGERY CENTER**

Field 3:
UZO-BILL-FREQ

***** VALUE**
- **0 NON-PAYMENT/ZERO CLAIM**
- **1 ADMIT THTOUGH DISCHARGE CLAIM**
- **2 INTERIM - FIRST CLAIM**
- **3 INTERIM - CONTINUING CLAIM**
- **4 INTERIM - LAST CLAIM**
- **5 LAST CHARGE(S) ONLY CLAIM**
- **6 ADJUSTMENT OF PRIOR CLAIM**
- **7 REPLACEMENT OF PRIOR CLAIM**
- **8 VOID/CANCEL PRIOR CLAIM**

TABLE 8
Place of Service
Updated 1/20/06 from Provider Manual of 11/1/05

2 BYTE	MAPS TO	DESCRIPTION
00-03	0	UNASSIGNED
04-08	3	OFFICE
11	3	OFFICE
12	4	HOME
13-14	0	UNASSIGNED
13-14	0	UNASSIGNED
21	1	INPATIENT
22	2	OUTPATIENT
23	2	EMERGENCY ROOM HOSPITAL
24	B	AMBULATORY SURGICAL CENTER
25	3	BIRTHING CENTER
26	D	MILITARY TREATMENT FACILITY
27-30	0	UNASSIGNED
31	8	SKILLED NURSING FACILITY
32	7	NURSING FACILITY
33	8	CUSTODIAL CARE FACILITY
34	4	HOSPICE
35-40	0	UNASSIGNED
41	9	AMBULANCE - LAND
42	9	AMBULANCE - AIR OR WATER
43-49	0	UNASSIGNED
50	D	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51	1	INPATIENT PSYCHIATRIC FACILITY
52	5	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	D	COMMUNITY MENTAL HEALTH CENTER
54	7	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	1	RESIDENTAL SUBSTANCE ABUSE TREATMENT FACILITY
56	1	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
57-60	0	UNASSIGNED
61	1	COMPREHENSIVE INPATIENT REHABILITATION FACILITY
62	1	COMPREHENSIVE OUTPATIENT REHABILITATION FACIL
63-64	0	UNASSIGNED
65	F	END STAGE RENAL DISEASE TREATMENT FACILITY
66-70	0	UNASSIGNED
71	D	STATE OF LOCAL PUBLIC HEALTH CLINIC
72	D	RURAL HEALTH CLINIC
73-80	0	UNASSIGNED
81	A	INDEPENDENT LAB
82-98	0	UNASSIGNED
99	0	OTHER UNLISTED FACILITY

TABLE 8
Place of Service
Updated 3/21/06 from HHS.PROD.TABLES & CMS WEBSITE

2 BYTE	MAPS TO	DESCRIPTION
00-03	0	OTHER UNLISTED FACILITY
04-08	3	OFFICE
11	3	OFFICE
12	4	HOME
13-14	0	OTHER UNLISTED FACILITY
15	3	OFFICE
20	3	OFFICE
21	1	INPATIENT
22	2	OUTPATIENT
23	2	EMERGENCY ROOM HOSPITAL
24	B	AMBULATORY SURGICAL CENTER
25	3	BIRTHING CENTER
26	D	MILITARY TREATMENT FACILITY
27-30	0	OTHER UNLISTED FACILITY
31	8	SKILLED NURSING FACILITY
32	7	NURSING FACILITY
33	7	CUSTODIAL CARE FACILITY
34	4	HOSPICE
35-40	0	OTHER UNLISTED FACILITY
41	9	AMBULANCE - LAND
42	9	AMBULANCE - AIR OR WATER
43-48	0	OTHER UNLISTED FACILITY
49	3	OFFICE
50	D	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51	1	INPATIENT PSYCHIATRIC FACILITY
52	D	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	D	COMMUNITY MENTAL HEALTH CENTER
54	7	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	1	RESIDENTAL SUBSTANCE ABUSE TREATMENT FACILITY
56	1	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
57	D	NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
58-59	0	OTHER UNLISTED FACILITY
60	D	MASS IMMUNIZATION CENTER
61	1	COMPREHENSIVE INPATIENT REHABILITATION FACIL
62	2	COMPREHENSIVE OUTPATIENT REHABILITATION FACIL
63-64	0	OTHER UNLISTED FACILITY
65	F	END STAGE RENAL DISEASE TREATMENT FACILITY
66-70	0	OTHER UNLISTED FACILITY
71	D	STATE OF LOCAL PUBLIC HEALTH CLINIC
72	D	RURAL HEALTH CLINIC
73-80	0	OTHER UNLISTED FACILITY
81	A	INDEPENDENT LAB
82-98	0	OTHER UNLISTED FACILITY
99	0	OTHER UNLISTED FACILITY

Table 8Z PATIENT STATUS
Updated 1/27/06
Values for UB92:
PATIENT STATUS

01 DISCHARGED TO HOME OR SELF CARE
02 DISCHARGED/TRANSFERRED TO ANOTHER SHORT-TERM GENERAL HOSPITAL
03 DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY
04 DISCHARGED/TRANSFERRED TO INTERMEDIATE CARE FACILITY
05 DISCHARGED/TRANSFERRED TO TYPE OF INSTITUTION
06 DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF HOME HEALTH SERV
07 LEFT AGAINST MEDICAL ADVISE
08 DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF HOME IV PROVIDER
09 ADMITTED AS AN INPT TO THIS HOSPITAL (MEDICARE OR TRICARE OUTPT CLAIM)
20 EXPIRED
30 STILL PATIENT
31 STILL PATIENT - SCF ADMINSTRATIVE DAYS PROGRAM PATIENT
32 STILL PATIENT - ICF ADMINSTRATIVE DAYS PROGRAM PATIENT
40 EXPIRED AT HOME (MEDICARE OR TRICARE FOR HOSPICE CARE)
41 EXPIRED IN MEDICAL FACILITY, E.G., HOSP, SNF, ICF, OR HOSPICE
42 EXPIRED, PLACE UNKNOWN
50 HOSPICE - HOME
51 HOSPICE - MEDICAL FACILITY
61 DISCHARGE/TRANSFER SAME FACILITY TO MEDICARE SWING BED
62 DISCHARGE/TRANFER TO INPATIENT REHABILITATION FACILITY
63 DISCHARGE/TRANSFER TO MEDICARE CERTIFIED LONG TERM CARE HOSPITAL
64 DISCHARGE/TRANSFER TO NURSING FACILITY CERTIFIED UNDER MEDICAID (BUT NOT MEDICARE)
65 DISCHARGE/TRANSFER TO PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART OF HOSPITAL
66 DISCHARGE/TRANSFER TO CRITICAL ASSESS HOSPITAL
71 DISCHARGE/TRANSFER/REFERRAL TO ANOTHER FACILITY FOR OUTPT SERVICES
72 DISCHAGE/TRANSFER/REFERRAL TO SAME FACILITY FOR OUTPT SERVICES

TABLE 9
Provider Types
Last Updated 1/20/06

CODE	DESCRIPTION
00	NURSING HOME
01	INPATIENT HOSPITAL
02	OUTPATIENT HOSPITAL
04	MENTAL HEALTH (PVT)
10	MENTAL/REHAB
15	BUY-IN
16	EPSDT
19	OTHER MEDICAL PROF
20	PHYSICIAN,OSTEOPATH IND
21	PHYSICIAN,OSTEOPATH GRP
22	MEDICAL CLINICS
30	DENTIST, IND
31	DENTAL, GRP
32	OPTICIANS
33	OPTOMETRIST, IND
34	OPTOMETRIST, GRP
35	PODIATRIST, IND
36	PODIATRIST, GRP
37	CHIROPRACTOR, IND
38	CHIROPRACTOR, GRP
41	OPTICIAN, GRP
60	HOME HEALTH AGENCY
61	CLTC, INDIVIDUAL
62	CLTC, GROUP
70	PHARMACY
76	DURABLE MEDICAL EQUIPMENT
80	INDEPENDENT LABORATORY
81	X-RAY
82	AMBULANCE SERVICE
84	MEDICAL TRANSPORTATION
85	CAP AGENCIES
89	MCCA
96	MISCELLANEOUS
97	DUR
98	WITHOUT VALID PROV TYPE

Table 10
Provider Specialty
Last Updated 07/08/10

CODE	DESCRIPTION
AA	PEDIATRIC SUB-SPECIALIST
EN	DENTAL - ENDODONTIST
LT	LICENSED MARRIAGE AND FAMILY THERAPIST
PC	LICENSED PROFESSIONAL COUNSELOR
PE	DENTAL - PERIODONTIST
SW	LICENSED INDEPENDENT SOCIAL WORKER
00	NO SPECIFIC MEDICAL SPECIALTY
01	THERAPIST/MULTIPLE SPECIALTY GROUP
02	ALLERGY AND IMMUNOLOGY
03	ANESTHESIOLOGY
04	AUDIOLOGY
05	CARDIOVASCULAR DISEASES
06	MIDWIFE
07	CHIROPRACTIC
08	DENTISTRY
09	DERMATOLOGY
10	EMERGENCY MEDICINE
11	ENDOCRINOLOGY AND METAB.
12	FAMILY PRACTICE
13	GASTROENTEROLOGY
14	GENERAL PRACTICE
15	GERIATRICS
16	GYNECOLOGY
17	HEMATOLOGY
18	INFECTIOUS DISEASES
19	INTERNAL MEDICINE
20	PVT MENTAL HEALTH
21	NEPHROLOGY/ESRD
22	NEUROLOGY
23	NEUROPATHOLOGY
24	NUCLEAR MEDICINE
25	NURSE ANESTHETIST
26	OBSTETRICS
27	OBSTETRICS AND GYNECOLOGY
28	SCDMH
29	OCCUPATIONAL MEDICINE
30	ONCOLOGY
31	OPHTHALMOLOGY
32	OSTEOPATHY
33	OPTICIAN
34	OPTOMETRY
35	ORTHODONTICS
36	OTORHINOLARYNGOLOGY
37	HOSPITAL PATHOLOGY
38	PATHOLOGY
39	PATHOLOGY, CLINICAL
40	PEDIATRICS
41	PEDIATRICS, ALLERGY
42	PEDIATRICS, CARDIOLOGY
43	PEDODONTICS
44	INDEPENDENT LAB - PRICING ONLY
45	PHYSICAL MEDICINE & REHABILITATION
46	XRAY - LAB - PRICING ONLY

47	PODIATRY
48	PSYCHIATRY
49	PSYCHIATRY, CHILD
50	FEDERALLY QUALIFIED HEALTH CLINICS
51	DHEC
52	PULMONARY MEDICINE
53	NEONATOLOGY
54	RADIOLOGY
55	RADIOLOGY, DIAGNOSTIC
56	RADIOLOGY, THERAPEUTIC
57	RHEUMATOLOGY
58	FEDERALLY FUNDED HEALTH CLINICS (FF
59	SUPPLIER (DME)
60	HOME HEALTH - PRICING ONLY
61	SURGERY, CARDIOVASCULAR
62	SURGERY, COLON AND RECTAL
63	SURGERY, GENERAL
64	AMBULANCE - PRICING ONLY
65	SURGERY, NEUROLOGICAL
66	SURGERY, ORAL (DENTAL ONLY)
67	SURGERY, ORTHOPEDIC
68	SURGERY, PEDIATRIC
69	SURGERY, PLASTIC
70	SURGERY, THORACIC
71	SURGERY, UROLOGICAL
72	CLINIC SCREENERS - PRICING ONLY
73	PHYSICIAN SCREENERS - PRICING ONLY
74	PROSTHETICS & ORTHOTICS PRICE ONLY
75	INDIVIDUAL TRANS - PRICING ONLY
76	CAP - PRICING ONLY
77	CLTC
78	MULTIPLE SPECIALTY GROUP
79	CLTC - ALTERNATE
80	OUTPATIENT-PRICING ONLY
81	OUTPATIENT-ALTERNATE PRICING SPECIA
82	PSYCHOLOGIST
83	SOCIAL WORKER
84	SPEECH THERAPIST
85	PHYSICAL/OCCUPATIONAL THERAPIST
86	NURSE PRACTITIONER
87	OCCUPATIONAL THERAPIST
88	HOSPICE
89	CORF
90	ALCOHOL & DRUG ABUSE
91	MENTAL RETARDATION
92	SED CHILDREN
93	AMBULATORY SURGERY
94	DIABETES EDUCATOR
95	DEVELOPMENTAL REHABILITATION
96	FAMILY PLANNING, MATERNAL & CHILD H
97	RURAL HEALTH CLINICS (RHC)
98	PRIVATE DUTY NURSING
99	PEDIATRIC NURSE PRACTITIONER

TABLE 11
Emergency Room Indicator
Last Updated 1/27/06

E - Outpatient Hospital Claim with ER revenue code
N or spaces - Either no Revenue code found or not an Outpatient Hospital Claim

TABLE 12
Gender
Last Updated 1/27/06

1 MALE
2 FEMALE
3 EITHER(unborn)

TABLE 13
RECIPIENT RACE
updated March 8, 2011

01 WHITE/CAUCASIAN
02 BLACK/AFRICAN AMERICAN
03 MULTI-RACE
04 FEDERALLY RECOGNIZED NATIVE AMERICAN
05 OTHER NATIVE AMERICAN
06 ALASKA NATIVE
07 ASIAN
08 OTHER/UNKNOWN
09 NATIVE HAWAIIAN/PACIFIC ISLANDER
10 HISPANIC

Table 14
Living Arrangement
Updated 1/27/06

Code Description
HOME CLIENT LIVES IN HOME
MED MEDICAL FACILITY
INST NON-MEDICAL FACILITY
COM COMMUNITY CARE
UNK UNKNOWN

Table 15
RECIPIENT FACILITY TYPE
Updated 1/27/06

AFC ADULT FOSTER CARE
BI BOARDING INSTITUTION
DIS DISABLED AND HOME
ECF EXTENDED CARE FACILITY
EMD HOMES FOR EMOTIONALLY DISTURBED INDIVIDUALS
FOS FOSTER CHILD
HH CLIENT ACTS AS HEAD/JOINT HEAD OF HOUSEHOLD
HOS HOSPITAL
HWH HALF WAY HOMES
ICF INTERMEDIATE CARE FACILITY
MAT MATERNITY HOMES
OTH OTHER
PRG PREGNANT AND HOME
PAR HOME OF PARENT
REL HOME OF RELATIVE
SCH SCHOOL
SNH SKILLED NURSING HOME
STM STATE HOSPITAL - MENTAL
STP STATE PARK - TUBERCULOSIS
UNB UNBORN CHILD

TABLE 16
Payment Message Indicator
Updated 6/26/06

Values for Claim Type A (HIC):
Payment Message Indicator
0 LINE-FORCED
1 HIO-SURG-PERCENTAG 50%
2 HIO-SURG-PERCENTAG 100%
3 HIO-SURG-PERCENTAG 150%
HIO-FRAGMENTED-PROC-CODE (A-F)
4 MODIFIERS-080-081-OR-082
A HIO-THREE-PROC-CODES
B HIO-FOUR-PROC-CODES
C HIO-FIVE-PROC-CODES
D HIO-SIX-PROC-CODES
E HIO-SEVEN-PROC-CODES
F HIO-EIGHT-PROC-CODES
P HIO-HCPC-PANEL-LINE
N HIO-ENCOUNTER-LINE
Z CHIROPRACTOR-VISIT
7 INDICATES SURGICAL PROC

Values for Claim Type A (Oral Surgeons):
Surgical Indicator
Y INDICATES ORAL SURGEON

Values for Claim Type G:
Level of Care
1 NHO-SKILLED-NURSING
2 NHO-ICF
3 NHO-ICF-MR
4 NHO-RESPIRATORY
5 NHO-PSYCH-CARE
6 NHO-SKILL-EXTENDED
7 OSS-OPTIONAL-STATE-SUPPLEMENT
8 IPC-INTERPERSONAL-CARE

Values for Claim Type D (DRUG):
Drug Class
1 - LEGEND DRUG
2 - LEGEND MULT SRCE
3 - OVER-THE-COUNTER
4 - OTC MULT SOURCE
5 - FED MAC LEGEND
6 - STATE MAC LEGEND
7 - DESI/IRS/LTE DRUG

Values for Claim Type J (BUYIN & PREMIUMS):
None

Values for Claim Type Z (HOSPITAL):
UZO-REIMBURSE-TYPE
BLANK UZO-NON-PPS-CLAIM
A-U UZO-DRG-CLAIM
A STRAIGHT-DRG
B UZO-TRANSFER-NO-OUTLIER
C UZO-COST-OUTLIER-NO-TRANSFER
D UZO-DAY-OUTLIER-NO-TRANSFER
E UZO-TRANSFER-COST-OUTLIER
F UZO-TRANSFER-DAY-OUTLIER
G UZO-PER-DIEM-PPS
H UZO-PER-DIEM-DRG-NO-OUTLIER
J UZO-PER-DIEM-DRG-COST-OUTLIER
K UZO-PER-DIEM-DRG-DAY-OUTLIER
L UZO-SAME-DAY-PER-DIEM-PPS
M UZO-SAME-DAY-DRG-NO-OUTLIER
N DRG-COST-OUTLIER
P UZO-PER-DIEM-INFREQ-DRG
Q UZO-P-D-I-DRG-OVER-THRESH
R UZO-P-D-I-DRG-PART-ELIG
S UZO-PDI-DRG-OVTHRSH-PRT-ELIG
T UZO-PDI-DRG-SAME-DAY-STAY
U UZO-ONE-DAY-STAY-DRG
1-5 UZO-OUTPATIENT-FEE-CLM
1 UZO-SURGERY-OUTFEE
2 UZO-EMERGENCY-OUTFEE
3 UZO-CLINIC-OUTFEE
4 UZO-TREAT-THERAPY-TESTS
5 UZO-NON-SURGERY-OUTFEE
9 UZO-ESRD-CLAIM

Table 17
Provider Status
Last updated 1/20/06

1 ACTIVE ELIGIBLE
(Enroll status is for providers that are located in the state of South Carolina and also for providers that are Out of State but within the South Carolina service area and the county code is 1-46, 60 or 62. (See attached file of the states that are considered within the South Carolina service area Medicaid Svc Aea Normal Practice_1.doc)
2 ACTIVE PRIOR AUTHOR
(Enroll status is for providers that are Out of State and outside the South Carolina Service Area and the county code is 61, 63 or 64)
3 TERMINATED-INVOL
(Enroll status is for internal use to identify providers that have been terminated due to returned mail/unable to locate provider, non-participation/file maintenance, NO NPI, etc.)
4 TERMINATED-VOL
(Enroll status is for providers that have requested verbally or in writing to be terminated)
5 SUSPENDED-INVOL
(Enroll status is for providers that have been placed on suspension by the Division of Program Integrity. Authorization to remove the status can only come from the Dvision of Program Integrity)
7 ACT DO NOT PAY T 18
(We do not use this enroll status for enrolling type 30 and 31 providers and I do not have policy and procedures that covered the enrollment for this status. As for the status description, it's means that the provider can only bill for straight Medicaid services reimbursement, Medicare reimbursement not allowed. However, we have nine instate providers that are currently enrolled effective 01/01/78 and one currently enrolled effective 06/01/88 with this status.

8 ACTIVE PA-NOT T 18
(Enroll status not used for Type 30 and 31)
9 AC MEDICARE-NO T 19
(Enroll status not used for Type 30 and 31

TABLE 18
Provider Ownership
Last Updated 06/25/08

00A MUSC - FED SHARE ONLY
00B PUBLIC DSH FED SHARE ONLY
00C PVT DSH STATE & FED SHARE
00D PUBLIC FED SHARE ONLY
001 NON-PROFIT ORG
002 PRIVATELY OWNED
003 PROPRIETARY (CHAIN)
004 HOSPITAL BASED
005 NURSING HOME BASED
006 STATE GOVT (NOT SC)
007 PUBLIC NOT STATE GOVT
008 DISPENSING PHYSICIAN
009 DOE FED SH ONLY CHECK
010 DEPT MENTAL HEALTH
011 DEPT DISABIL & SPEC NEEDS
012 DHEC-DHHS STATE SHARE
014 VOCATIONAL REHAB
015 U.S.C.
016 D.S.S.
017 DHEC-DHEC STATE SHARE
018 GOVERNORS OFFICE
019 DAODAS
020 CONTINUUM OF CARE
021 SCHOOL - DEAF & BLIND
022 MUSC DISP SHARE
023 MUSC STATE SHARE
024 DEPT JUVENILE JUSTICE
025 COMMISSION FOR BLIND
026 CLEMSON UNIVERSITY
027 DOE IDT
028 JOHN DE LA HOWE
029 WIL LOU GRAY
030 STATE HOUSING AUTHORITY

TABLE 19
Drug Therapeutic Class
Updated 01/20/06

XXXXXX DRUG NOT ON FORMULARY
000001 ANTI-NEOPLASTIC PREPARATION
000002 BLOOD MODIFIERS
000003 CENTRAL NERVOUS SYSTEM
000004 DIURETICS AND CARDIOVASCULAR
000005 GASTROINTESTINAL DRUGS
000006 FAMILY PLANNING DRUGS
000007 HORMONES
000008 MISCELLANEOUS PRODUCTS
000009 NUTRITIONAL PRODUCTS
000010 RESPITORY DRUGS
000011 SYSTEMIC ANTI-INFECTIVES
000012 TOPICAL PREPARATIONS
999999 SPECIAL AUTHORIZATION

Table 20 Category of Service

01 INPATIENT HOSP GEN
03 INPATIENT HOSP MENTAL
04 RESIDENTIAL TREAT FAC
06 CLINIC SVCS-MENTL/REHAB
07 OUTPATIENT HOSP GEN
08 HMO
10 NH-INST MNTAL DISEASE
11 SKILLED NURSING FAC
12 SNF TB
13 ICF-MENTAL RETARDTION
16 INTERMED CARE FAC-ICF
19 CLTC SERVICE
20 HOME HEALTH SVCS
21 HMO PREMIUM PAYMENTS
22 BUY-IN
23 (INDEP) LAB/X-RAY
27 FAMILY PLANNING SVCS
30 PRESCRIBED DRUGS
32 DURABLE MEDICAL EQUIP
37 AMBULANCE SERVICE
40 EPSDT SCREENING
41 EPSDT DIAG & TREAT
43 PHYS & OSTEO SVCS
45 DENTAL SVCS
47 OPTOMETRIC SVCS
55 PODIATRISTS SVCS
57 CHIROPRACTIC SVCS
61 MEDICAL TRANS
70 CLINICAL SVCS
71 PARAPROF SVCS
72 MISCELLANEOUS
99 OTHER

Table 20 Cross Reference with Provider Type

Category of Service	Provider Type/s
01 INPATIENT HOSP GEN	01 INPATIENT HOSPITAL
03 INPATIENT HOSP MENTAL	
04 RESIDENTIAL TREAT FAC	
06 CLINIC SVCS-MENTL/REHAB	10 MENTAL/REHAB
07 OUTPATIENT HOSP GEN	02 OUTPATIENT HOSPITAL
08 HMO	
10 NH-INST MNTAL DISEASE	
11 SKILLED NURSING FAC	00 NURSING HOME (SEE NOTE #1 BELOW)
12 SNF TB	
13 ICF-MENTAL RETARDTION	00 NURSING HOME (SEE NOTE #2 BELOW)
16 INTERMED CARE FAC-ICF	00 NURSING HOME (SEE NOTE #3 BELOW)

19 CLTC SERVICE	**61,62 CLTC, INDIVIDUAL & GROUP**
20 HOME HEALTH SVCS	**60,52 HOME HEALTH AGENCY**
21 HMO/MHN	**15 MEDICARE/HMO PREMIUMS**
22 BUY-IN	
23 (INDEP) LAB/X-RAY	**80,81 Indep Lab/X-Ray**
27 FAMILY PLANNING SVCS	
30 PRESCRIBED DRUGS	
32 DURABLE MEDICAL EQUIP	**76 DURABLE MEDICAL EQUIPMENT**
37 AMBULANCE SERVICE	
40 EPSDT SCREENING	**16 EPSDT**
41 EPSDT DIAG & TREAT	
EPSDT REFERRAL PRESENT (EPSDT IND = Y)	
43 PHYS & OSTEO SVCS	
45 DENTAL SVCS	**30,31 DENTAL, INDIVIDUAL OR GROUP**
47 OPTOMETRIC SVCS	**33,34 OPTOMETRIST, INDIVIDUAL OR GROUP**
55 PODIATRISTS SVCS	**35,36 PODIATRIST, INDIVIDUAL OR GROUP**
57 CHIROPRACTIC SVCS	**37,38 CHIROPRACTOR, INDIVIDUAL OR GROUP**
61 MEDICAL TRANS	**84,85 MEDICAL TRANSPORTATION, CAP**
70 CLINICAL SVCS	
71 PARAPROF SVCS	
72 MISCELLANEOUS	
99 OTHER	

TABLE 21 LANGUAGE CODE

LANGUAGE CODE 3 BYTE 639-2 ISO	DESCRIPTION
ARA	ARABIC
CHI	CHINESE
ENG	ENGLISH
FRE	FRENCH
GER	GERMAN
GRE	GREEK
GUJ	GUJARATI
HAT	HAITIAN-CREOLE
HIN	HINDI
HMN	HMONG
ITA	ITALIAN
JPN	JAPANESE
KHM	KHMER
KOR	KOREAN
LAO	LAOTIAN -LAO
MDR	MANDARIN (MANDAR)
PER	FARSI - PERSIAN
POL	POLISH
POR	PORTUGUESE
RUS	RUSSIAN
SGN	AMERICAN SIGN LANGUAGE
SMO	SAMOAN
SPA	SPANISH
TGL	TAGALOG
TUR	TURKISH
UKR	UKRANIAN
UND OR ART OR MIS	*DEFAULT TO ENG
VIE	VIETNAMESE
YID	YIDDISH

1 byte Language Codes (used in MLE)

E	English
S	Spanish
M	Mandarin
P	Portuguese
V	Vietnamese
H	Hindi
K	Korean
C	Cantonese
G	Gujarati
R	Russian
A	Arabic
T	Turkish
B	Polish
D	Farsi
F	French

I Italian
J Japanese
L Laotian
N Hmong
O Other
Q German
U Ukranian
W Armenian
X Khmer
Y Yiddish
Z Greek
1 Samoan
2 Haitian-Creole
3 American Sign Language
4 Chinese
5 Tagalog

Table 22 834 Race Code

A Asian or Pacific Islander
B Black
C Caucasian
E Other Race or Ethnicity
G Native American (so we can distinguish between Federally Recognized and others)
H Hispanic
I American Indian or Alaska Native
J Native Hawaiian
7 Not Provided