DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers/FOIA	4-29-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100516	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Singleton, Stenoland Cleared 5/13/09, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 5-13-09 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

*i*Health Technologies

April 27, 2009

Felicity Myers, Ph.D.
Deputy Director of Medical Services
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202

Re: Freedom of Information Act Request

Dear Dr. Myers:

Thank you for taking the time to meet with us regarding *i*Health Technologies' Payment Policy Management Solution. The subsequent meeting with Laurel Eddins and Kevin Rogers was very informative. *i*Health Technologies is confident that a partnership with the South Carolina Department of Health and Human Services would enhance Medicaid payment policy and administration that would result in cost savings for the State.

Pursuant to South Carolina Code of Laws, Sections 30-4-10 et seq., as amended, *i*Health Technologies is requesting claims information for outpatient hospital services and professional services as outlined in the attached Application for Use of Medicaid Data, Outpatient File Layout, Professional File Layout and Other Requested Files. This information is being requested for the purpose of conducting an analysis to demonstrate the potential impact of the Payment Policy Management Solution offered by *i*Health Technologies.

Thank you again for allowing us the opportunity to meet with you and your staff about payment policy management. We look forward to sharing the results of our analysis with you.

Sincerely,

*i*Health Technologies

Mark A. Besh
Executive Vice President

William J. McIvor
Executive Vice President

Enclosures

115 Perimeter Center West • Suite 700 • Atlanta, GA 30346 • phone. 770.379.2800 • fax. 770.379.2803

Application for Use of Medicaid Data
Stored by the Office of Research and Statistics

A. Application Information

Name of Requestor:	Patrick McGonigal		
Job Title:	Senior Vice President, Finance		
Organization:	*i*HT Government Services, LLC, a wholly-owned subsidiary of *i*Health Technologies, Inc.		
Address:	115 Perimeter Center Place The South Terraces Suite 700 Atlanta, GA 30346		
Phone Number:	770-379-2856	**Fax Number:**	770-379-2908
Email Address:	pat.mcgonigal@ihealthtechnologies.com		
Title of Study:	Analysis of Payment Policy Management Impact		
Previous Data Requests:	None		
Today's Date:	April 23, 2009		

B. Data Request

Data Elements Requested:	Please See Attached Data Request Documentation
Selection Criteria for Database: ***Please specify the variables and variable values to be used for selecting records:***	Please See Attached Data Request Documentation

Elements: *Please specify in Month(s) and Year(s)*	
Desired Electronic Medium:	Secure FTP or Encrypted CD

C. Study Protocol and Project Activities

Describe how the purpose of the study or project relates to the Medicaid State Plan administration (See 42 CFR 431.302) (if applicable)	The objective of the analysis is to identify the cost avoidance and policy compliance improvements achieved by deploying the iHealth Technologies payment Policy Management Solution. This will be illustrated by applying a standard set of policies to one years worth of paid claims data to demonstrate how claims would have be adjusted and paid.
Cite legal authority for obtaining the data (if applicable)	We have attached a FOIA request as a cover letter to this document to assure full disclosure
Explain the study objectives and hypotheses, where applicable	The study objectives are to demonstrate the impact of Payment Policy Management with a high degree of statistical integrity. By identifying the potential corrections using paid claims data, we are able to accurately project the potential of implementing the program for the State of SC.
Indicate if the proposal analysis will be used for legal, administrative or other actions that may directly affect particular individuals, health care providers or professionals or state agencies or other organizations	The results of this analysis are intended for SCDHHS leadership and staff only and will not be shared outside of this group unless instructed by the Agency.
Please describe other data which will be used/linked in this study	Please see the attached Data
Describe the analysis to be performed. If analysis is to be completed by multiple organizations/entities, specify what analysis each organization/entity will perform.	iHealth Technologies will apply a standard set of payment policies to SC claims. This will be a conservative rule set comprised of AMA CPT code standards and CMS National Correct Coding guidelines. By providing actual claim line examples in 40 categories of payment policy, SC DHHS staff will have actual claim correction details to accurately assess program accuracy and compliance. iHT personnel and Todd Galloway, actuarial consultant, will work on this analysis.

Explain the benefits of the study	SC DHHS will have an accurate assessment of the potential impact of deploying the Payment Policy Management solution
Describe any other intended use of the data or additional plans for release of the data	The data will be used exclusively for simulating this impact of correct coding.

Format/Level of Data to be Re-released	**Please see Attached Data Request Documentation**

D. Security Measures

Describe the procedures for protecting the confidentiality of Medicaid data in accordance with 42 CFR 431.300 et seq., Code of Laws of South Carolina (1976) Volume 27, as amended, copies of which are attached.	iHealth Technologies considers all client data as highly confidential and will comply with the procedures for protecting the confidentiality of **Medicaid data in accordance with 42 CFR 431.300 et seq., Code of Laws of South Carolina (1976) Volume 27, as amended.** **It is important to note that the data sent to iHealth Technologies will contain a very limited amount of PHI information to include Provider ID, and encrypted Subscriber ID. In addition analyst access to this data will be ona restricted database with restricted access based on Oracle role level security.** IHT Information Security Policy Framework **Foreword** iHealth Technologies, Inc. (iHT) regards its information and information systems as valuable business assets, fundamental to the long-term existence of the Company. In addition, our clients expect us to maintain the confidentiality and security of their information that comes into our possession. Protection of Company assets and the confidentiality and security of client information are implicit in our core values. Therefore, it is the responsibility of all Company personnel to take appropriate measures to maintain the confidentiality, integrity and availability of these assets and to protect them against accidental or unauthorized modification, disclosure or destruction. Each of us bears personal accountability for the proper use and security of our information systems and the information and data they contain. The policy framework statement that follows provides a foundation for the planning, implementation, enforcement and maintenance of information security across the Company. Each of us must be aware of our responsibilities and carry them out in our daily activities. Information security is a continuous process; the active support of this policy by all iHT personnel is vital. Given the speed of technology's evolution, it is not possible to exhaustively list every possible inappropriate use of iHT information systems and the information and data they contain. All iHT personnel are expected to demonstrate common sense and good judgment in the use of the Company's information systems and their content, and to educate themselves about the security practices that

should be followed. The iHT collection of Security Policies sets out the policies and practices to which each of us is expected to adhere, including information technology security, electronic security, software use and use of e-mail. These policies are applicable to all iHT personnel, regardless of function or position.

Information Security Objective

iHT's objective is to protect its information assets and those of its clients in a manner consistent with their importance, value and sensitivity and in accordance with applicable legal and regulatory requirements, which include privacy requirements and the protection of intellectual property. This Information Security Policy Statement is meant to summarize the applicable portions of the iHT Security policies and identifies guiding principles for achieving that objective. These policies will be amended, supplemented and supported from time to time by one or more documents giving further guidance on appropriate Information Security practices.

Scope

iHT's Information Security Policies apply to all iHT's electronic communications systems, including but not limited to access methods, e-mail, Internet access, intranet and voice mail. It applies to the use of such systems whenever you access them, whether or not during normal working hours, and whether or not you are on iHT premises.

Guiding Principles

While no policy governing electronic communications systems can possibly address every issue created by the use of such systems, the vast majority of potential problems regarding the use of iHT's electronic communications systems can be avoided by the application of five simple principles:

- **OBEY THE LAW** – It is the responsibility of each iHT employee to be aware of and to comply with applicable laws and government regulations covering use of information systems. Do not use iHT infrastructure or resources to engage in illegal activity, such as using iHT systems as a staging ground or platform to gain unauthorized access to other systems or violating copyright or other intellectual property rights.
- **HIPAA REQUIREMENTS** - With the Security and Privacy regulations laid out in HIPAA, it is no longer just good business sense to protect our information and systems – it is a legal requirement. Our management also has a fiduciary duty to preserve, protect, and account for information used by and entrusted to us and the systems used to store and manage it. This means iHT must take appropriate steps to ensure that information and information systems are properly protected from a variety of threats such as error, fraud, embezzlement, sabotage, terrorism, extortion, industrial espionage, privacy violation, service interruption, and natural disaster.
- **iHT RESOURCES ARE FOR iHT WORK** – It is important for all iHealth personnel to remember that inappropriate conduct in the use of information technology and other forms of electronic communication can lead to risk for iHealth and its clients. Do not use iHealth resources for personal commercial, fundraising, lobbying, political or other inappropriate activities, including personal use that gives the appearance that a personal opinion is being expressed or a transaction is being conducted on the part of the Company.
- **RESPECT THE RIGHTS OF OTHERS** –Do not use iHealth or client systems or facilities in a way that is offensive to fellow employees or to the public, such as creating, copying or transmitting hate speech or material that is offensive in the way it addresses issues of race, creed, religion, gender, disability, age or national origin. Do not use iHealth or client systems to view,

	download, store, transmit or copy materials that are sexually explicit or sexually oriented or that are related to gambling, illegal weapons, terrorist activities or for any other offensive activities. • **PROTECT THE RIGHTS AND PROPERTY OF IHEALTH AND ITS CLIENTS** – It is the responsibility of all iHealth personnel to take all reasonable steps to protect iHealth and client equipment and information under their control. Do not engage in any personal use of iHealth or client information systems that endangers the confidentiality of iHealth or client information. Protect information systems from unauthorized access by preventing unauthorized use of passwords. • **DO NO HARM** – Each employee bears personal responsibility and accountability for the proper use and security of iHealth and client information systems and the information and data they contain. Do not engage in non-business communications that reduce the efficiency of the network, place unapproved software on iHealth or client computers, make configuration changes that circumvent security settings, or distribute information that inappropriately discloses confidential or proprietary information. **Compliance** **iHealth's Information Security Policies apply to all iHealth personnel and others who have access to iHealth data or information systems. Your compliance with these policies is mandatory. iHealth will take violations very seriously, and they may lead to termination of your authorization to use Company systems as well as to immediate disciplinary action up to and including the termination of your employment. With respect to outside vendors or third party consultants, violation of this policy may result in the termination of your authorization to use the network and the termination of your relationship with iHealth.** If you have any questions regarding the scope or application of this policy, you should direct such questions to a member of the Information Security Team.
Describe what methods will be used to physically secure the data	iHealth Technologies considers the security of client data our utmost priority. Client data is delivered via encrypted FTP to iHealth Technologies, moved and loaded to our restricted access analysis database,. This database is housed in a caged environment within our Sungard co-location facility. Sungard is a leader in co-location services and provisions a facility with 24 security staff, video cameras, and access restrictions. Our corporate environment where data will be accessed has network controls in place through firewalls, network authentication, and application authentication. The physical office environment maintains 24 hour building security, badge access and video monitoring of all entry and exit points.
Describe the plans for disposal of restricted and confidential data elements upon completion of the project.	When the project has completed our database staff will delete the State of South Carolina table space from the analysis database. This data will then be purged from the system. There is another option at client discretion to archive the data for future projects if requested, otherwise all data will be expunged from the system.

Confidentiality Contract for the Use of Medicaid Data
Stored by the Office of Research and Statistics

Applications for the release of restricted and confidential data elements require the Requestor to submit a signed confidentiality contract to the Office of Research and Statistics (ORS) with a list of the names and titles of all persons who will have access to the data including: employees, subcontractors and committee members. All persons with access to the data will be required to sign a confidentiality contract, which will be held by the Requestor for review upon request by the SCDHHS. I agree to the following confidentiality requirements related to the use or release of restricted and/or confidential data elements:

1. I will not allow others to nor will I myself use the data elements for purposes other than the study purposes and the purposes specified in this application. Use of restricted data elements for a research project other than the one described in this application will not be undertaken until a separate form for that project has been submitted to and approved by the SCDHHS.

2. I shall preserve the confidentiality of/anonymity of clients and providers by observing the following conditions:

    i. Confidentiality/anonymity of clients and providers is to be preserved in accordance with 42 CFR 431.300 (1996, as amended), et seq, and SCDHHS Regulations 126-170, et seq, Code of Laws of South Carolina (1976), Volume 27, as amended, copies of which are attached hereto and labeled as Attachment A and Attachment B; and

    ii. All persons who are to have access to Medicaid data files will be given a copy of the relevant CFR sections and State Regulations and asked to read those sections and to sign the following certification:

    "I acknowledge that I have read 42 CFR 431.300 (1996, as amended), et seq, and SCDHHS Regulations 126-170 et seq., and I agree to be bound by the confidentiality conditions contained therein."

3. I will not allow others to nor will I myself release, furnish, disclose, publish or otherwise disseminate these data in any manner other than those approved and specified in this application.

4. I will not allow others to nor will I myself use this data to identify any individual.

5. I will not allow others to nor will I myself re-release the identity of any individual.

6. I will not allow others to nor will I myself use this data to identify any health care facility and/or professional without prior SCDHHS approval.

7. I will not allow others to nor will I myself publish, disseminate, communicate or otherwise re-release health care facility and/or professional identifiable data without prior approval by the SCDHHS and review and comment by the affected facilities.

8. I will not allow others to nor will I myself match this data set(s) to other patient level data sets by use of patient, health care facility and/or professional level characteristics without prior approval by the SCDHHS.

9. I will not allow others to nor will I myself release data in a report or for dissemination will a cell size of less than 5 without prior approval by the SCDHHS.

10. A full disclosure of how the data are to be used and the safeguards used for the storage of data are included with this application. (Please submit any changes to the security procedure outlined in the application to the SCDHHS.)

11. Restricted and/or confidential data elements will be destroyed or returned to the Office of Research and Statistics (ORS) upon completion of the research project. Aggregate data and reports based on confidential data and/or restricted data shall be stored under appropriate security measures.

12. The data must remain solely with the original project entity. A new application must be submitted in the event of a proposed change of the lead entity for the project.

13. In the event of a change in the Requestor, a newly signed Confidentiality Contract must be submitted to the ORS within 90 days.

14. I have the authority to assume the responsibility, on behalf of myself and my organization (if applicable), to insure that the data is used as specified and I, and my organization, will be responsible for the use/misuse of these data.

15. Reports containing restricted and/or confidential data must be marked "Confidential. Not For Release".

Name and Title of Requestor:
Patrick McGonigal, Senior Vice President, Finance
Organization/Firm Name (Branch, Division, Department, etc.):
***i*Health Technologies, Inc.**
Address (City, State, Zip Code):
115 Perimeter Center Place
Suite 700
Atlanta, GA 30346
Telephone (with area code):
770-379-2856
Fax Number (with area code):
770-379-2908
Other individuals having access to these data include the following:
The data will be housed in a secure database, with access limited to a four person claims analysis unit.
Name, Position and Address:

Name, Position and Address:

Name, Position and Address:

Name, Position and Address:

Name, Position and Address:

By signing this document, I agree to comply with all the confidentiality requirements indicated in this document.

Signature of Requestor: Patrick McGonigal

Date: 4-23-09

Outpatient File Layout

Outpatient File Layout

Outpatient File Data Detail

This document depicts the preferred standard file format for *i*Health Technologies (*i*HT) Integrated Claim Management Services (ICMS) system. While it is preferable to map the claim line detailed data to *i*HT's specific file formats (listed below), it is not necessary. Please make note of any changes. It is also preferable to have the data elements listed as "optional" but not required to assess claim saving opportunities.

Please provide claims incurred in Calendar 2008 (between Jan. 1, 2008 and Dec. 31, 2008) and adjudicated through March 31, 2009.

*i*HT Field Name	Description	Type	Length	Required ?
SUB_ID	**Subscriber ID**: The member's encrypted unique subscriber identification number.	Text	20	Required
CLAIM_ID	**Header Claim ID**: unique claim identification number.	Text	25	Required
DOB	**Date of Birth**: listed on the claim	Date	8	Required
GENDER_ID	**Gender**: listed on the claim. Recommended values are M for Male, F for Female, and U for Unknown.	Text	10	Required
ORG_CLAIM_ID	**Original Claim ID**: In situations where adjustments result in a new claim number on a client's claim system, the original claim ID allows the new claim resulting from the adjustment to be linked back to the original claim	Text	25	Required
CLAIM_DOS_FROM	**Header Date of Service From**: the date on the UB-92 for the entire claim. ASC claims will not use this field, but instead the line level DOS_FROM.	Date	8	Required
CLAIM_DOS_TO	**Header Date of Service To:** the date on the UB-92 for the entire claim. ASC claims will not use this field, but instead the line level DOS_TO.	Date	8	Required
LINE_SEQ	**Claim Line Number**: the sequential number associated to the line number on the claim. As an example: the number 002 should be passed for the second line on the claim.	Numeric	3	Required
LINE_DOS	**Detail Date of Service From**: This is field 45 on the UB-92 claim form.	Date	8	Required
ADJ_DATE	**Adjudication Date**: the date the claim was adjudicated.	Date	8	Required
HEADER_STATUS	**Header Status**: the status on the claim header. Please provide a narrative definition of all claim header statuses.	Date	8	Required
DETAIL_STATUS	**Detail Status**: the status on the claim line. Please provide a narrative definition of all claim line statuses.	Date	8	Required
BILL_TYPE	**Bill Type**: Position 4 on the UB-92 claim. This three digit code requires 1 digit each, in the following sequence: 1) Type of facility 2) Bill classification, and 3) Frequency	Text	3	Required

iHT Field Name	Description	Type	Length	Required ?
CLAIM_TYPE	**Claim Type**: Outpatient facility claims are identified with a value of "O". Freestanding ASC's are identified by "S".	Text	1	Required
PROVIDER_ID	**Facility ID**: a single facility identification number that is unique to the facility in the client's system. If a facility has more than one identifying number, a loss of savings could occur due to logic that would or would not invoke inappropriately. This is field 51 on the UB-92 claim form that corresponds to the current client.	Text	25	Required
CONTRACT	**Contract**: If a facility has multiple contracts, the value in this field should represent the contract identification number associated with the claim submitted.	Text	25	*Optional*
SUB_REV_CODE	**Revenue Code**: field 42 on the UB-92 claim form.	Text	4	*Optional*
SUB_HCPCS	**Submitted HCPCS**: the first five positions of field 44 on the UB-92 claim form.	Text	5	*Optional*
SUB_MOD1	**Submitted Modifier 1**: the sixth and seventh positions of field 44 on the UB-92	Text	2	*Optional*
SUB_MOD2	**Submitted Modifier 2**: the eighth and ninth positions of field 44 on the UB-92	Text	2	*Optional*
SUB_MOD3	**Submitted Modifier 3**: the third procedure code modifier submitted by the provider for this service line. This field is typically only available via electronic formats.	Text	2	*Optional*
SUB_MOD4	**Submitted Modifier 4**: the fourth procedure code modifier submitted by the provider for this service line. This field is typically only available via electronic formats.	Text	2	*Optional*
SUB_UNITS	**Submitted Units**: the number of units submitted by the provider for this service. This is field 46 on the UB-92 claim form.	Numeric	3	*Optional*
SUB_AMOUNT	**Submitted Amount**: The value in this field represents the amount charged submitted by the provider for this service. This is field 47 on the UB-92 claim form.	Numeric	10	Required
ALLOWED_REV_CODE	**Allowed Rev Code**: the revenue code approved for payment by the client for this service line.	Text	4	Required
ALLOWED_HCPCS	**Allowed HCPCS**: the procedure code approved for payment by the client for this service line.	Text	5	*Optional*
ALLOWED_MOD1	**Allowed Modifier 1**: the first procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*
ALLOWED_MOD2	**Allowed Modifier 2**: the second procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*
ALLOWED_MOD3	**Allowed Modifier 3**: the third procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*

*i*HT Field Name	Description	Type	Length	Required ?
ALLOWED_MOD4	**Allowed Modifier 4**: the fourth procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*
ALLOWED_UNITS	**Allowed Units**: the number of units approved by the client for this service.	Numeric	3	Required
ALLOWED_AMOUNT	**Allowed Amount**: the allowed amount (before applying copay, coinsurance, deductible, cob, & other reduction) approved by the client for this service.	Numeric	10	Required
COPAY	**Copay**: the patient's copay amount for this service.	Numeric	10	Required
COINSURANCE	**Coinsurance**: the patient's coinsurance amount for this service.	Numeric	10	Required
DEDUCTIBLE	**Deductible**: the patient's deductible amount for this service.	Numeric	10	Required
COB	**COB**: the patient's COB or TPL amount for this service.	Numeric	10	Required
OTHER_REDUCTION	**Other Reductions**: any other adjustment amounts not reflected above.	Numeric	10	Required
PAID	**Paid**: the paid amount (after applying copay, coinsurance, deductible, cob, & other reduction) approved by the client for this service.	Numeric	10	Required
CONDITION_CODE_1	**Condition Code 1**: the condition code in field 24 on the UB-92 claim form. This field is used to indicate the patient's eligibility and benefits and how to administer the primary and secondary insurances.	Text	2	*Optional*
CONDITION_CODE_2 CONDITION_CODE_3 CONDITION_CODE_4 CONDITION_CODE_5 CONDITION_CODE_6 CONDITION_CODE_7	**Cond. Code 2**: field 25 on the UB-92 **Cond. Code 3**: field 26 " " **Cond. Code 4**" field 27 " " **Cond. Code 5**" field 28 " " **Cond. Code 6**" field 29 " " **Cond. Code 7**" field 30 " "	Text	2	*Optional*
PRINCIPAL_DIAGNOSIS	**Principal Diagnosis**: the principal condition established after evaluation and treatment. This is field 67 on the UB-92 claim form. For ASC claims this field is Diagnosis Code 1.	Text	6	Required
DIAGNOSIS_2	**Secondary Diagnosis**: the diagnosis that co-exists in addition to the principal diagnosis reported in field 68 on the UB-92 claim form. For ASC claims, this field is Diagnosis Code 2.	Text	6	*Optional*
DIAGNOSIS_3	**Tertiary Diagnosis**: the diagnosis that co-exists in addition to the principal diagnosis reported in field 69 on the UB-92 claim form. For ASC claims, this field is Diagnosis Code 3.	Text	6	*Optional*
DIAGNOSIS_4	**4th Diagnosis**: field 70 on the UB-92. For ASC claims, this field is Diagnosis Code 4.	Text	6	*Optional*

*i*HT Field Name	Description	Type	Length	Required ?
DIAGNOSIS_5	**5th Dx**: field 71 on UB; or Dx code 5 on ASC	Text	6	*Optional*
DIAGNOSIS_6	**6th Dx**: " " 72 on UB; " " 6 on ASC	"	"	
DIAGNOSIS_7	**7th Dx**: " " 73 on UB; " " 7 on ASC	"	"	
DIAGNOSIS_8	**8th Dx**: " " 74 on UB; " " 8 on ASC	"	"	
DIAGNOSIS_9	**9th Dx**: " " 75 on UB; " " 9 on ASC	"	"	
DIAGNOSIS_10	**10th Dx**: " " 76 on UB; " " 10 on ASC	"	"	
DIAGNOSIS_11	**11th Dx**: " " 77 on UB; " " 11 on ASC	"	"	
DIAGNOSIS_12	**12th Dx**: " " 78 on UB; " " 12 on ASC	"	"	
DIAGNOSIS_13	**13th Dx**: " " 79 on UB; " " 13 on ASC	"	"	
ADMITTING_DIAGNOSIS	**Admitting Diagnosis**: field 76 on the UB-92 claim form.	Text	6	*Optional*
E_CODE_DIAGNOSIS	**External Diagnosis**: field 77 on the UB-92 claim form.	Text	6	*Optional*

Additional Format Specifications:

The following are additional preferred (but not necessary) format specifications as they relate to the field types, such as Text, Numeric or Dates.

- The standard file format is ASCII fixed width.
- Text fields should be left justified (blank filled on the right where necessary)
- Numeric fields should be right justified (zero filled on the left where necessary)
- Date fields should be in format YYYYMMDD
- Dollar amount and diagnosis code fields have an implied decimal (e.g. a dollar amount of $100.00 would come in as 0000010000 and a diagnosis code of 300.81 would come in as 30081)

Professional File Layout

Professional File Layout

Professional File Data Detail

This document depicts the preferred standard file format for *i*Health Technologies (*i*HT) Integrated Claim Management Services (ICMS) system. While it is preferable to map the claim line detailed data to *i*HT's specific file formats (listed below), it is not necessary. Please make note of any changes. It is also preferable to have the data elements listed as "optional" but not required to assess claim saving opportunities.

Please provide claims incurred in Calendar 2008 (between Jan. 1, 2008 and Dec. 31, 2008) and adjudicated through March 31, 2009.

*i*HT Field Name	Description	Type	Length	Required ?
SUB_ID	**Subscriber ID**: The member's encrypted unique subscriber identification number.	Text	20	Required
DOB	**Date of Birth**: listed on the claim	Date	8	Required
GENDER_ID	**Gender**: listed on the claim. Recommended values are M for Male, F for Female, and U for Unknown.	Text	10	Required
CLAIM_ID	**Header Claim ID**: unique claim identification number.	Text	25	Required
ORG_CLAIM_ID	**Original Claim ID**: In situations where adjustments result in a new claim number on a client's claim system, the original claim ID allows the new claim resulting from the adjustment to be linked back to the original claim	Text	25	Required
DOS_FROM	**Date of Service From**: the Date of Service From field on the CMS-1500.	Date	8	Required
DOS_TO	**Date of Service To**: the Date of Service To field on the CMS-1500. In order to make appropriate adjudication recommendations, date ranges need to be transmitted. The lack of date ranges could cause inappropriate recommendations. As an example: a provider bills a date range for two days and a procedure with two units of service corresponding to the date range. If the Date of Service From is the only date passed to *i*HT, one unit could be denied as exceeding the number of units allowed on a single date of service.	Date	8	Required
LINE_SEQ	**Claim Line Number**: the sequential number associated to the line number on the claim. As an example: the number 002 should be passed for the second line on the claim.	Numeric	3	Required
ADJ_DATE	**Adjudication Date**: the date the claim was adjudicated.	Date	8	Required
HEADER_STATUS	**Header Status**: the status on the claim header. Please provide a narrative definition of all claim header statuses.	Date	8	Required

*i*HT Field Name	Description	Type	Length	Required ?
DETAIL_STATUS	**Detail Status**: the status on the claim line. Please provide a narrative definition of all claim line statuses.	Date	8	Required
POS_ID	**Place of Service**: the place where the service was rendered. *i*HT uses industry standard place of service codes. If the client uses non-industry standard place of service codes, please provide a list of the values and their descriptions for mapping purposes.	Text	2	Required
CLAIM _TYPE	**Claim Type**: the type of Claim (Professional, ASC, or Other Facility) that was submitted. Valid values are 'P', 'A' or 'F'. (If claim type is not available or the other claim types are not applicable for the interface, default with 'P'.)	Text	1	Required
PROVIDER_ID	**Provider ID**: a single physician identification number that is unique to the physician in the client's system. If a physician has more than one identifying number, there could be an impact to adjudication recommendations which should be discussed with *i*HT	Text	25	Required
SUB_HCPCS	**Submitted HCPCS**: The value in this field represents the procedure code submitted by the provider for this service.	Text	5	Required
SUB_MOD1	**Submitted Modifier 1**: the first procedure code modifier submitted by the provider for this service.	Text	2	*Optional*
SUB_MOD2	**Submitted Modifier 2**: the second procedure code modifier submitted by the provider	Text	2	*Optional*
SUB_MOD3	**Submitted Modifier 3**: the third procedure code modifier submitted by the provider	Text	2	*Optional*
SUB_MOD4	**Submitted Modifier 4**: the fourth procedure code modifier submitted by the provider	Text	2	*Optional*
SUB_UNITS	**Submitted Units**: the number of units submitted by the provider for this service.	Numeric	3	Required
SUB_AMOUNT	**Submitted Amount**: the charge amount submitted by the provider for this service.	Numeric 9(8)V99	10	Required
ALLOWED_HCPCS	**Allowed HCPCS**: the procedure code approved for payment by the client for this service.	Text	5	Required
ALLOWED_MOD1	**Allowed Modifier 1**: the first procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*
ALLOWED_MOD2	**Allowed Modifier 2**: the second procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*
ALLOWED_MOD3	**Allowed Modifier 3**: the third procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*
ALLOWED_MOD4	**Allowed Modifier 4**: the fourth procedure code modifier approved for payment by the client for this service line.	Text	2	*Optional*
ALLOWED_UNITS	**Allowed Units**: the number of units approved by the client for this service.	Numeric	3	Required

iHT Field Name	Description	Type	Length	Required ?
ALLOWED_AMOUNT	**Allowed Amount**: the allowed amount (before applying copay, coinsurance, deductible, cob, & other reduction) approved by the client for this service.	Numeric	10	Required
COPAY	**Copay**: the patient's copay amount for this service.	Numeric	10	Required
COINSURANCE	**Coinsurance**: the patient's coinsurance amount for this service.	Numeric	10	Required
DEDUCTIBLE	**Deductible**: the patient's deductible amount for this service.	Numeric	10	Required
COB	**COB**: the patient's COB or TPL amount for this service.	Numeric	10	Required
OTHER_REDUCTION	**Other Reductions**: any other adjustment amounts not reflected above.	Numeric	10	Required
PAID	**Paid**: the paid amount (after applying copay, coinsurance, deductible, cob, & other reduction) approved by the client for this service.	Numeric	10	Required
LINE_SEQ_ORIG	The original line sequence is used to more accurately report payment variance and invoice data for edited TBA lines that are returned in history with one or multiple different line sequence numbers. It links newly created lines back to the original line number that generated the change recommendation.	Numeric	3	*Optional*
DIAGNOSIS_CODE_1	The value in this field represents the header level diagnosis listed in the number one position on the CMS-1500 submitted by the provider. To provide accurate adjudication recommendations on the claim, all diagnosis codes submitted by the provider should be transmitted on the file with appropriate pointers. **Note: It is expected that all lines of a claim will include the same header level diagnosis codes.**	Text	6	Required
DIAGNOSIS_CODE_2	The value in this field represents the header level diagnosis listed in the number two position on the CMS-1500	Text	6	*Optional*
DIAGNOSIS_CODE_3	The value in this field represents the header level diagnosis listed in the number three position on the CMS-1500	Text	6	*Optional*
DIAGNOSIS_CODE_4	The value in this field represents the header level diagnosis listed in the number four position on the CMS-1500	Text	6	*Optional*
DIAGNOSIS_CODE_5	The value in this field represents the header level diagnosis listed in the number five position on the CMS-1500	Text	6	*Optional*
DIAGNOSIS_CODE_6	The value in this field represents the header level diagnosis listed in the number six position on the CMS-1500	Text	6	*Optional*
DIAGNOSIS_CODE_7	The value in this field represents the header level diagnosis listed in the number seven position on the CMS-1500	Text	6	*Optional*

iHT Field Name	Description	Type	Length	Required ?
DIAGNOSIS_CODE_8	The value in this field represents the header level diagnosis listed in the number eight position on the CMS-1500	Text	6	*Optional*
DIAG_PTR1	The value in this field represents the ICD-9 pointer that correlates the line service to one of the eight header level diagnosis codes. As an example: if this line corresponds to the diagnosis in the number two position on the CMS-1500, then this pointer should be set to 2.	Numeric	1	Required
DIAG_PTR2	The value in this field represents the ICD-9 pointer that correlates the line service to one of the eight header level diagnosis codes. As an example: if this line corresponds to the diagnosis in the number two position on the CMS-1500, then this pointer should be set to 2.	Numeric	1	*Optional*
DIAG_PTR3	The value in this field represents the ICD-9 pointer that correlates the line service to one of the eight header level diagnosis codes. As an example: if this line corresponds to the diagnosis in the number two position on the CMS-1500, then this pointer should be set to 2.	Numeric	1	*Optional*
DIAG_PTR4	The value in this field represents the ICD-9 pointer that correlates the line service to one of the eight header level diagnosis codes. As an example: if this line corresponds to the diagnosis in the number two position on the CMS-1500, then this pointer should be set to 2.	Numeric	1	*Optional*

Additional Format Specifications:

The following are additional preferred (but not necessary) format specifications as they relate to the field types, such as Text, Numeric or Dates.

- The standard file format is ASCII fixed width or delimited.
- Text fields should be left justified (blank filled on the right where necessary)
- Numeric fields should be right justified (zero filled on the left where necessary)
- Date fields should be in format YYYYMMDD
- Dollar amount and diagnosis code fields have an implied decimal (e.g. a dollar amount of $100.00 would come in as 0000010000 and a diagnosis code of 300.81 would come in as 30081)

Other Requested Files

Provider File Layout

Please provide information from your provider table(s). iHT should be able to link PROVIDER_ID in the professional and outpatient claims files to the provider files below.

*i*HT Field Name	Description	Type	Length	Required ?
PROVIDER_ID	**Provider ID**: a single physician or facility identification number that is unique to the physician in the client's system. If a physician or facility has more than one identifying number, there could be an impact to adjudication recommendations which should be discussed with *i*HT	Text	25	Required
TAX_ID	**Tax ID**: The value in this field represents the provider's tax identification number. This number should represent the individual or group practice.	Text	9	Required
AFFILIATION_ID	**Affiliation ID**: any other Group or Affiliation number associated with the Provider ID	Text	25	*Optional*
NATL_PROV_ID	**NPI**: CMS National Provider Identifier for the provider of service.	Numeric	10	*Optional*
PROVIDER_CITY	**Provider County:** the city associated with the address of the billing provider	Text	20	*Optional*
SPECIALTY_ID_1	**Provider Subspecialty**: the physician's specialty or subspecialty used to pay the claim. As an example: ORTH or 0015 for orthopedics, PEDCAR or 0030 for pediatric cardiology, etc. In order to make appropriate adjudication recommendations on the claim, the provider's specialty must be identified. Blank values in this field can be mapped to a "miscellaneous" specialty which will limit payment policies that will be applied, if this method is chosen by the client.	Text	10	Required
SPECIALTY_ID_1_desc	**Provider Subspecialty Description**: any text field describing the SPECIALTY_ID_1 code	Text	50	*Optional*
SPECIALTY_ID_2	**Provider Subspecialty 2**: any second specialty code mapped to the billing provider	Text	10	*Optional*
SPECIALTY_ID_2_desc	**Provider Subspecialty Description 2**: any text field describing the SPECIALTY_ID_2 code	Text	50	*Optional*
SPECIALTY_ID_3	**Provider Subspecialty 3**: any third specialty code mapped to the billing provider	Text	10	*Optional*
SPECIALTY_ID_3_desc	**Provider Subspecialty Description 3**: any text field describing the SPECIALTY_ID_3 code	Text	50	*Optional*
PAR_YN	**Non-Par Providers**: If a provider is paid differently than other Medicaid providers, such as out-of-state or "non-par" providers, the value of this field would be "N". Valid values are 'Y' or 'N'. (If participating status is not available, default with 'Y'.)	Text	1	*Optional*

Member File Layout

Please provide information from your member eligibility table(s). iHT should be able to link SUB_ID in the professional and outpatient claims files to the member files below.

iHT Field Name	Description	Type	Length	Required / Optional / Conditional
SUB_ID	The value in this field should represent the member's unique subscriber identification number.	Text	20	Required
DOB	**Date of Birth**	Date	8	Required
GENDER_ID	**Gender**: Recommended values are M for Male, F for Female, and U for Unknown.	Text	10	Required
COA_ID	**Category of Aid (COA)**: This is typically an internal code that identifies broad Medicaid grouping categories (eg. Waiver eligible, SSI without Medicare, SSI with Medicare, TANF, SCHIP, etc) *Since COAs can change throughout a members eligibility span, please just provide the COA as one point in time.*	Text	25	*Optional*
COA_ID_desc	**COA description**: any text field describing COA_ID	Text	25	*Optional*
RATE_CODE	**Rate Code (RC)**: any secondary level of eligibility grouping after COA. *Since RCs can change throughout a members eligibility span, please just provide the RC as one point in time*	Text	25	*Optional*
RATE_CODE_desc	**RC description**: any text field describing RC_ID	Text	25	*Optional*

Control Totals

Please provide the following control data to help validate the data are accurate and complete.

- Professional Files:
  - Total # of records
  - Total Submitted Charges
  - Total Allowed Units
  - Total Allowed Charges
  - Total Paid Charges

- Outpatient Files:
  - Total # of records
  - Total Submitted Charges
  - Total Allowed Units
  - Total Allowed Charges
  - Total Paid Charges

From: Origin ID: TMAA (770) 913-2711
Patty Taylor
iHealth Technologies
115 Perimeter Center Place
Suite 700
Atlanta, GA 30346

FedEx Express

Ship Date: 28APR09
ActWgt: 1.0 LB
CAD: 4793966/INET9011
Account#: S *********

Delivery Address Bar Code

SHIP TO: (770) 913-2700 BILL SENDER
Felicity Myers, PHD
SC Dept of Health and Human Svcs.
1801 Main Street

Columbia, SC 29202

Ref # Bill McIvor
Invoice #
PO #
Dept #

WED - 29APR A1
STANDARD OVERNIGHT

TRK# 0201 7965 5680 7650

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After printing this label:
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2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

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Log #616

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

May 13, 2009

Mr. William J. McIvor
Executive Vice President
iHealth Technologies
115 Perimeter Center West, Suite 700
Atlanta, Georgia 30346

Dear Mr. McIvor:

We are in receipt of your request for data to conduct an analysis for pre-payment review, related to your Payment Policy Management Solution. We have reviewed the detailed list of data elements requested and there are concerns over the protection of client identification. Kevin Rogers, of my staff, is coordinating a meeting with our legal staff, Susan Bowling of Kerr and Company, and your staff to discuss these issues and agree to the specific data elements that will be released. This meeting is in the process of being scheduled.

I am sure you understand the importance of protecting the confidentiality of Medicaid data, and we appreciate your patience as we come to an agreement both parties are comfortable with.

Sincerely,

Felicity Myers, Ph.D.
Deputy Director

FM/rm

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