

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>10-20-08</i>
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DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOC NUMBER  <i>000216</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR  <i>CC: Ms. For Lner</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____		
<i>Change to 11/4 per Jolue</i> <i>on 10/23/08 E-mail attached</i>		<input type="checkbox"/> FOIA DATE DUE _____	
		<input checked="" type="checkbox"/> Necessary Action DATE DUE _____	

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

**From:** Felicity Myers  
**To:** Brenda James  
**Date:** 10/23/2008 4:22 pm  
**Subject:** Log 216

Brendan  
Please relog as necessary action

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR**

**ACTION REFERRAL**

TO  <i>Myers</i>	DATE  <i>10-20-08</i>
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1. LOG NUMBER  <i>000216</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR  <i>CE: Ms. Forlner</i> <i>4</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>10/27/08</i>  <input type="checkbox"/> FOIA DATE DUE _____  <input type="checkbox"/> Necessary Action

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

**From:** Rhonda Morrison  
**To:**  
**CC:** POLATTYJ@scdhhs.gov  
**Date:** 10/17/2008 7:54 PM  
**Subject:** Fwd:

David Hinson forwarded me the attached OIG request for data. It references an enclosure which didn't make it in the email so Jan, if you receive the hardcopy to Emma, please forward it to Kevin's group (right, Kevin?).

David said the OIG is having trouble obtaining MSIS data from CMS (imagine) so they are having to go to the states to get it. Looks like they want 2007 claims data.

Rhonda W. Morrison, Bureau Chief  
Bureau of Federal Contracts  
S.C. Dept of Health & Human Services  
Office: 803-898-2999  
morrison@scdhhs.gov

**RECEIVED**

OCT 20 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General  
SERVICE, Office of Audit Services  
REGION IV

nr'T 1 5 '8 61 Forsyth Street, S.W., Suite 3T41

01

4., Atlanta, Georgia 30303

Ms. Emma Forkner, Director

South Carolina Department of

Health and Human Services

1801 Main Street

Columbia, South Carolina 29201

**RECEIVED**

OCT 20 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Dear Emma Forkner:

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) is requesting extracts of Medicaid files from your agency. As requested by the Centers for Medicare & Medicaid Services (CMS), HHS/OIG is expanding review efforts in the Medicaid fraud and abuse area.

OIG performs independent reviews of HHS programs pursuant to the Inspector General Act of 1978 (Act). Section 6(a)(1) of the Act (5 U.S.C. App., section 6(a)(1)) authorizes OIG "... to have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to [HHS] which relate to programs and operations with respect to which the Inspector General has responsibilities under this Act."

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, providing the information requested by this letter is a permitted disclosure since it (a) is "required by law" to be produced to the OIG as part of your participation in a government benefits program (45 CFR§164.512(a) and 164.103) and (b) will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (45 CFR§164.512(d) and 164.501).

Please see the enclosure, "Requested Columns by File Type," for specific information on the data request parameters. We are requesting extracts of Provider and Claim files within the following parameters:

- State fiscal year 2007 (Please specify time frame);
- claim dates of service;
- encrypted for transfer using an industry standard encryption methodology; and
- in the following media options:
  - o DVD;
  - o CD; or
  - o mainframe cartridge(s) e.g. 3480/3490.

Page 2 - Ms. Emma Forkner

A data dictionary, file layout, table descriptor, or similar documentation should accompany the data provided for each different file type. Please e-mail any passwords separately, or provide them over the telephone to the auditor below.

If you expect the amount of data to be small enough for a personal computer, please provide it on CD or DVD in a standard format such as text file or Access database. If the

file is too large to manipulate on a PC (i.e., it requires mainframe processing), the media should include the following:

- 18- or 36-track magnetic cartridge (tape) (36-track standard);
- standard IBM labels (tape format);
- tape volume serial number and data set name;
- record length and block size; and
- record layouts for each claim type.

Regardless of the format provided, please include reconciliation information to verify that the file is accurate and complete (i.e., a report with total record counts by file type).

If you provide tapes, we anticipate returning all of them to you upon completion of our processing.

We will arrange for a courier to pick up the media from you.

We would appreciate your prompt attention to this request.

If you have any questions or concerns about this data request, please call Dana Duncan at (404) 562-7775. Thank you in advance for your assistance.

Sincerely,

Peter J. Barbera

Regional Inspector General  
for Audit Services  
Enclosure





DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

*Original*

OCT 15 2008

REGION IV  
61 Forsyth Street, S.W., Suite 3T41  
Atlanta, Georgia 30303

Ms. Emma Forkner, Director  
South Carolina Department of  
Health and Human Services  
1801 Main Street  
Columbia, South Carolina 29201

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Sincerely,



Peter J. Barbera  
Regional Inspector General  
for Audit Services

Enclosure



**Requested Columns by File Type**

<b>Rx</b>	
Transaction control number (TCN)	Last Name
Accounting Code	Date of Birth
Claim status	Medicare Indicator
Input Form	Nursing Home Indicator
First date of service	Credit Indicator
Last date of service	TCN to Credit
Paid date	Prescription number
Total Charges	NDC Code
Recipient paid	Drug name
Third Party Liability (TPL) paid	Drug Strength
Medicare paid	Prescriber
Reimbursement amount	License
Provider number	Days supplied
Provider specialty	Quantity
Provider Type	Dispensing fee
Recipient ID	Allowed Charges
Recipient Original ID	Carrier Code
Assistance Category	Miscellaneous Provider Indicator
Poverty Indicator	Miscellaneous Provider
County	Procedure Code
ZIPcode	Procedure Code Modifier
First Name	Diagnosis Code

**Requested Columns by File Type**

**Capitation**

Transaction control number (TCN)  
Accounting Code  
Claim status  
Input Form  
First date of service  
Last date of service  
Paid date  
Total Charges  
Reimbursement amount  
Provider number  
Provider Type  
Provider County  
Recipient ID  
Recipient Original ID  
Assistance Category  
Poverty Indicator  
County  
ZIPcode  
Date of Birth  
First Name  
Last Name  
Medicare Indicator  
Nursing Home Indicator  
HMO Capitation Group  
Credit Indicator  
TCN to Credit  
FFP Indicator

**Line Item Information:**

Number of lines  
Submitted Units  
Units Allowed  
Allowed Charges  
Procedure Charge  
Procedure Code

**Requested Columns by File Type**

**Inpatient and Outpatient**

Input Form	Attending Provider Number
Accounting Code	Attending Provider License
Claim status	Performing Provider Number
First date of service	Performing Provider License
Last date of service	Provider Charge Factor
Paid date	Covered Days
Total Charges	Medicare Provider Number
Recipient paid	Patient Status
Third Party Liability (TPL) paid	Admission Date
Medicare paid	Diagnosis Codes
Reimbursement amount	Nursing Home Hospital Days
Provider number	Nursing Home Home Days
Provider specialty	Nursing Home Termination Code
Provider Type	Nursing Home Action Code
Pay to Provider	Nursing Home Discharge Code
Pay to Provider Type	Nursing Home Discharge Date
HMO Indicator	Surgical Procedure Codes
Recipient ID	Medicare Deductible
Recipient Original ID	Medicare Coinsurance
Assistance Category	Medicare Date Paid
Poverty Indicator	FFP Indicator
County	
ZIPcode	
Date of Birth	<b>Line Item Information:</b>
First Name	Total Number of Lines
Last Name	Procedure Code
Medicare Indicator	Modifier – 1 <sup>st</sup>
Nursing Home Indicator	Modifier – 2 <sup>nd</sup>
HMO Capitation Group	Modifier – 3 <sup>rd</sup>
Credit Indicator	Modifier – 4 <sup>th</sup>
Transaction control number (TCN)	Service Date
TCN to Credit	Units of service
Allowed Charges Total	Revenue Code
Allowed Charge Source	Allowed Charges

Requested Columns by File Type

Medical

Transaction control number (TCN)	Diagnosis Code
Accounting Code	Private Transportation Type
Claim status	Trip Code
Input Form	Private Transportation Patient Status
First date of service	Injury Code
Last date of service	Injury Date
Paid date	Provider Treating
Total Charges	Provider Referring
Recipient paid	Medicare Approved Amount
Third Party Liability (TPL) paid	Medicare Deductible
Medicare paid	Medicare Coinsurance
Reimbursement amount	FFP Indicator
Provider number	Third Party Liability (TPL) Carrier Code
Provider specialty	Miscellaneous Provider Indicator
Provider Type	Miscellaneous Provider
Provider County	
Provider ZIPcode	
HMO Indicator	
Recipient ID	<b>Line Item Information:</b>
Recipient Original ID	Number of Lines
Assistance Category	Date of Service
Program Code	Submitted Units of Service
Poverty Indicator	Units of service
County	Allowed Charges
ZIPcode	Procedure Charge
Date of Birth	TPL Amount
First Name	Diagnosis Codes
Last Name	Facility Code
Medicare Indicator	Place of Service
Nursing Home Indicator	Procedure Code
HMO Capitation Group	Modifier – 1st
Credit Indicator	Modifier – 2nd
TCN to Credit	Modifier – 3rd
	Modifier – 4th

**Requested Columns by File Type**

**Provider/Prescriber Table**  
Number  
Name  
Street Address (1<sup>st</sup>)  
Street Address (2<sup>nd</sup>)  
City  
State  
Zipcode  
County Code  
County  
License Number  
Conv License Number  
Provider Type  
Provider Specialty  
Group Number  
Group Name