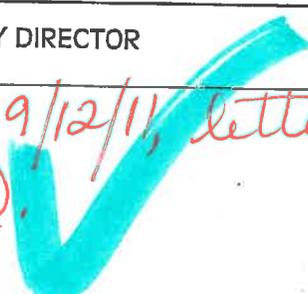


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Singleton</i>	DATE <i>8-8-11</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>101072</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>Claud 9/12/11, letter attached.</i> 	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>8-18-11</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.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-17
Baltimore, Maryland 21244-1850



Office of E-Health Standards and Services

Date of Notice: August 3, 2011

Bruce Carter
Attorney
South Carolina Department of Health and Human Sciences
1801 Main Street, 6th Floor
P.O. Box 8206
Columbia, SC 29201

RECEIVED

AUG 03 2011

SCDHHS
Office of General Counsel

Reference Number: 11TCS03764

Dear Mr. Carter,

On July 17, 2011, the Centers for Medicare & Medicaid Services (CMS) received a complaint concerning South Carolina Department of Health and Human Services' (SCDHHS) compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The complaint alleges that SCDHHS is rejecting claims because it requires proprietary data to process the Health Care Secondary Claims (837) Coordination of Benefits (COB) transactions.

It is our policy and responsibility to notify an entity that a complaint has been filed, and to provide that entity with the opportunity to respond with relevant facts to either dispute the claim, or to resolve it.

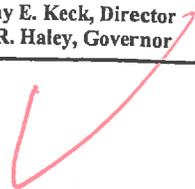
Since SCDHHS is a covered entity, we expect that you will investigate the complaint, and either:

- a. Dispute the allegations and provide evidence that SCDHHS is compliant and that no violation of the HIPAA rules has occurred; or
- b. Determine that the allegation has merit, and submit a Corrective Action Plan (CAP) with specific actions that will be taken, dates for those actions, key milestones for monitoring progress, and an expected completion date.

You must respond within 30 days of the date of this letter. We will review the information you submit, and will notify you if it is satisfactory, or if additional information is needed.

You may reply to this complaint via e-mail by submitting your response and documentation in Microsoft Word, Excel, or in PDF formats to the HIPAA complaint mailbox at hipaacomplaint@cms.hhs.gov, or write to the Office of E-Health Standards and Services (OESS) at:

Log #00072



September 12, 2011

Centers for Medicare and Medicaid Services
HIPAA Enforcement
Attn: Office of E-Health Standards and Services
P. O. 8030
Baltimore, Maryland 21244-8030

RE: Reference Number: 11TCS03764

Dear Ms. Wheeler:

On August 8, 2011, the South Carolina Department of Health and Human Services (SCDHHS) received your notice that a complaint had been received by your office regarding SCDHHS compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The complaint alleged that SCDHHS is rejecting claims because it requires proprietary data to process the Health Care Secondary Claims (837) Coordination of Benefits Transactions.

This letter is the SCDHHS response to the above complaint.

The SCDHHS Medicaid Management Information System (MMIS) at SCDHHS was revised to include a Third Party Liability (TPL) sub-system which houses all third party insurer and policy information. This sub-system was necessary to allow SCDHHS to meet its obligations under §1902(a)(25) [42 USC 1396a(a)(25)] regarding liable third parties.

At the time SCDHHS was working on its TPL sub-system, the Uniform Billing Committee of the South Carolina Hospital Association (SCHA) in South Carolina, in conjunction with the Office of Research and Statistics of the South Carolina Budget and Control Board, had already determined a need for payer identification codes to simplify electronic billing and coordination of benefits claims between payers. The result of this collaboration was a set of payer codes that are used by virtually all payers and providers in South Carolina. The payer codes are maintained by the SCHA and are available on their website at:

http://www.scha.org/files/documents/all_payer_codes_for_sc_numeric1.pdf - in numeric order, and

http://www.scha.org/files/documents/sc_alpha_payer_codes_codes.pdf - in alphabetical order. New codes to identify new payers can be created by contacting the SCHA with information about the payer and requesting a code. These codes are currently used by providers and payers in the processing of most institutional claims in South Carolina, according to the SCHA. SCDHHS incorporated the format for these codes into the design of its TPL sub-system and makes use of them for all claims involving other payers, whether

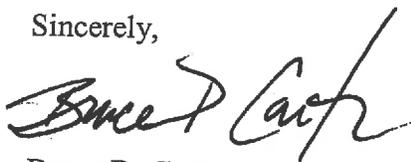
institutional or professional. A copy of the code sets are maintained in our provider manuals.

During the 4010 implementation, SCDHHS reviewed the implementation guides and interpreted the guides to mean that there was flexibility available in the approach to the content in the 837 professional claim transaction code set. The payer codes were not considered to be a problem because they are not proprietary to SCDHHS and are in current usage by virtually all providers and payers in South Carolina. Taking any other approach would also have required significant changes to the MMIS and the TPL sub-system. There would also have been disruption of SCDHHS's ability to cost avoid claims for which TPL information was available. To no longer make use of the codes that make it possible to have our TPL process highly automated would have resulted in additional costs to the agency because of the need to manually review claims that did not have the TPL code and manually update the TPL sub-system. SCDHHS did not interpret the implementation guidelines to mean that the use of the code set developed by the SCHA and the Office of Research and Statistics would not be allowed. Another reason that SCDHHS retained the use of the code set was that, at that time, there was an expectation that CMS would issue regulations regarding the establishment of a National Health Plan Identifier by early 2001 and the current system using the Payer Codes would have an advantage in being adaptable to a new National Health Plan Identifier.

SCDHHS believes that the complaint submitted regarding our compliance with HIPAA regarding Transaction Code set 837 is without merit. SCDHHS believes its process complies with the HIPAA requirements for non-institutional COB transactions. The Payer Codes being used are not proprietary, are readily available to anyone with access to the internet both at the SCDHHS website and the SCHA website. The implementation guide requires that we accept the information to which the submitter has access. If they have the name of the payer, they can access the code. Use of the code allows SCDHHS to fully utilize its TPL sub-system to identify whether or not other coverage exists; whether or not the payer information is the same as SCDHHS has on file; and whether or not the claim should be cost avoided. SCDHHS believes its process to be in compliance with both HIPAA requirements and its obligation under 42 USC §1396a(a)(25).

If you have any questions or I can be of additional assistance, please contact me at 803.898.2793 (office) or by email at carterbd@scdhhs.gov.

Sincerely,



Bruce D. Carter
Assistant General Counsel & Privacy Official