REPORT COMPANION GUIDE

4/1/2022
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 Managed Care 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 or the report template 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 Division of Managed Care/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		
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		
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
834 Report Layout	MCO receives these reports on a daily basis providing information on membership enrollment	Daily
Section 3.7		
Manual Maternity Kicker	Maternity Kicker Form for use when automated process does not function correctly	Monthly
Section 3.12		
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 3.18		
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		
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
Institution for Mental Disease (IMD)	Report provided to MCOs of members 21-64 with an IMD stay exceeding 15 days.	Annually
High Cost No Experience Drug	Reimbursement for high cost no experience pharmaceuticals	Monthly
COVID-19 Vaccine Administration	Reimbursement for COVID-19 Vaccine Administration	Monthly
Section 4.3		
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		
Care Management	Report of members receiving care management services on an ongoing basis with the MCO.	Monthly
Section 5.5		
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		
Provider Network	MCO report sent to SCDHHS reflecting MCOs entire provider network.	Bi-annually and as Requested

Report Companion Guide Section Layout and Reporting - continued

Managed Care Report Name	Format	Report Timing
Section 7		
Section 7.2		
Medical Loss Ratio (MLR)	Medical Loss Ratio Calculation report indicating the proportion of premium revenues spent on clinical services and quality improvement.	Annual
Section 7.3		
Premium Payment Adjustments	MCO's retroactive rate adjustment format.	As Necessary
Dual Medicare Medicaid	Report produced for the MCOs to account for retro-active dual eligible Medicare recoupments for up to a year in arrears.	Monthly
Monthly Premium Recoupment	Report produced for the MCOs for all members that received a premium payment in error.	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
MCO Withhold	Report template shared with the MCO to indicate quarterly withholding done to MCO's.	Quarterly
Section 7.4		
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 7.9		
Annual Audited Financial Statement	Should be the same report produced for the SC Department of Insurance.	Annually
Section 9		
Section 9.1		
Member Grievance anhd Appeal Log	Grievance and Appeal reporting required of the MCO.	Quarterly and Annually
Section 9.2		
Provider Dispute Log	Provider dispute reporting required of the MCO.	Quarterly
Section 10		
Section 10.9		
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		
Provider Notice	Form for reporting potential provider abuse fraud issues	As Necessary
Member Fraud and Abuse	Form for reporting potential member abuse and fraud issues	As Necessary
DHHS BEOMB	Beneficiary Explanation Of Medicaid 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
Good Cause Exception (GCE)	Notifies the MCOs of a potential fraud referral for a provider of which they may request a payment suspension exception.	As Necessary
Permissions	To request permission to conduct a targeted BEOMB run.	As Necessary
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
Annual Strategic Plan	Strategic Plan Matrix can be found at PI SharePoint site.	Annually
Section 11.2		
Written Compliance Plan	Compliance Plan Matrix can be found at PI SharePoint site.	Annually
Section 11.10		
Pharmacy LI Member Letter	Sample letter to send to members for Pharmacy Lock-In program.	As Necessary
Pharmacy LI Member Removal Letter	Sample letter to send to members for removal from the Pharmacy LI program.	As Necessary
Pharmacy LI Pharmacy Letter	Sample letter to send to pharmacies for the Pharmacy LI program.	As Necessary
Section 12		
Section 12.3		
Marketing Activities Submission Log	Log MCOs use to notify DHHS of upcoming marketing activities.	As Necessary
Section 13		
Section 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 14.10		
EQI	Encounter Quality Initiative	Quarterly, Annually
Section 15		
Section 15.1		
Population Assessment Report	NCQA defined	Annually
Section 15.3		
HEDIS and CAHPS	NCQA defined	Annually
Section 15.5		
APM	Alternative Payment Models	Annually
Section 16		
Section 16.3		
QA GRID	As necessary for the MCO to ask questions of their account manager	As Necessary-Returned weekly to MCO
Appendix E		
BabyNet Members	Report produced for the MCOs of members receiving BabyNet Services	Monthly
BabyNet Providers	Report produced for the MCOs of BabyNet Providers	Monthly

REPORT REQUIREMENTS

AS NECESSARY/DAILY

Managed Care Report Name	Format	Report Timing
Daily and As Necessary Reporting Requirements		
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Section 2.1		
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
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Section 3.2		
834 Report Layout	MCO receives these reports on a daily basis providing information on membership enrollment.	Daily
Section 3.12		
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
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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		
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 5.5		
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 7		
Section 7.3		
Premium Payment Adjustments	MCO's retroactive rate adjustment format.	As Necessary
Section 11		
Section 11.1		
Provider Notice	Form for reporting potential provider abuse fraud issues	As Necessary
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Provider Suspensions	SharePoint templates for reporting provider suspensions	As Necessary
Provider Exclusions	SharePoint templates for reporting provider exclusions	As Necessary
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Good Cause Exception (GCE)	Notifies the MCOs of a potential fraud referral for a provider of which they may request a payment suspension exception.	As Necessary
Permissions	To request permission to conduct a trargeted BEOMB run.	As Necessary
Section 11.10		
Pharmacy LI Member Letter	Sample letter to send to members for Pharmacy Lock-In program.	As Necessary
Pharmacy LI Member Removal Letter	Sample letter to send to members for removal from the Pharmacy LI program.	As Necessary
Pharmacy LI Pharmacy Letter	Sample letter to send to pharmacies for the Pharmacy LI program.	As Necessary
Section 12		
Section 12.3		
Marketing Activities Submission Log	Log MCOs use to notify DHHS of upcoming marketing activities.	As Necessary
Section 16		
Section 16.3		
QA GRID	As necessary for the MCO to ask questions of their account manager	As Necessary-Returned weekly to MCO

Section 2.1: 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: 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 3.2: 834 Report Layout: The 834 transcation file layout can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 3.12:

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

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.

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.

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.

Section 4.2:

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.

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

Section 4.3: Additional Services Form: If an MCO would like to provide additional services beyond the core benefit please complete the form found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Field definitions are 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 4.8: Member Incentive Form: If an MCO would like to utilize a member incentive above $25.00, please complete the form found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates and email it to the respective MCO Plan Manager. Approved/Denied forms will be uploaded by the Plan Manger to the MCO's Shared Documents folder on SharePoint/Office 365.

Field definitions are 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 5.5: Universal Newborn PA:
This form is available on the SCDHHS website at https://msp.scdhhs.gov/managedcare/site-page/reference-tools and is labeled Universal Newborn 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.

Section 7.3: 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:				Review ed:		
	Source:						

Section 11.1 Program Integrity:

Provider Notice: MCO should send when they suspect provider fraud. The instructions and template can be found at the PI SharePoint site.

Member Fraud and Abuse Referral Form: MCO should send when they suspect member fraud and abuse. The instructions and template can be found at the PI SharePoint site.

BEOMB Notificaiton Form: Beneficiary Explanation of Medicaid Benefits form for reporting instances where a member indicates that they did not receive a service from a provider. The instructions and template can be found at the PI SharePoint site.

Good Cause Exception (GCE) Form: Notifies the MCOs of a potential fraud referral for a provider of which they may request a payment suspension exception. The instructions and template can be found at the PI SharePoint site.

Permissions Form: To request permission to conduct a targeted BEOMB run. The instructions and template can be found at the PI SharePoint site.

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

Section 11.1:

Suspension, Termination, Exclusion excel lists are located in DHHS' Share Point site and are found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Program Integrity Instructions for use of SharePoint for Reporting Provider Suspensions, Terminations and Exclusions: can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Provider Suspension, Exclusions, and Terminations Templates: Found on Program Integrity SharePoint Site

Section 11.10: Pharmacy Lock-In Letters / Notifications

The templates must be used for Pharmacy Lock-In Member Notification (Pharmacy LI Member Letter), Member Instructions (Pharmacy LI Member INSTRUCTIONS rev 2-15-17), Member Removal (Pharmacy LI Member Removal Letter), and Pharmacy Notification (Pharmacy LI Pharmacy Letter). The only MCO modifications allowed to the templates are highlighted in yellow. These sections must be modified. Please note that the Pharmacy LI Member Letter should include language to address Section 1557 of the Patient Protection and Affordable Care Act Addendum.

The Pharmacy Lock-In letters/notifications can be found at:
https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 12.3: Marketing Activities Submission Log

This log is used for MCOs to document upcoming marketing activities they are participating in/sponsoring. The template has been added to each MCO's SharePoint Managed Care site under the "Required Submissions" library. Monthly Tabs are located at the bottom. Log your event under the tabs based on the month in which you are submitting the event information. For example: A future event for November 1, 2017 submitted in April, would be logged under the April 2017 tab. Events on the spreadsheet should be listed in the order of submission, but each column heading has a sorting option available.

PLAN NAME: _____

Submission Date	County	Event Date(s)	Name of Site and Name of Event	Is this a Sponsorship? Y/N	Address of Event	Event Hours	Event Contact Person Name, Title, & Phone #	Date of Participation Approval (by Event Sponsor)	Details of the Event	Social Media Use (Site Specific Tools)	Event Changes (cancel/ change

Section 16.3: QA Grid: On occasion the MCO's may need to ask questions of SCDHHS. SCDHHS has developed a form to allow plans the ability to ask questions of SCDHHS.

QA grid template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

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 3.7		
Manual Maternity Kicker	Maternity Kicker Form for use when automated process does not function correctly	Monthly
Section 3.18		
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		
High Cost No Experience Drug	Reimbursement for high cost no experience pharmaceuticals	Monthly
COVID-19 Vaccine Administration	Reimbursement for COVID-19 Vaccine Administration	Monthly
Section 5		
Section 5.4		
Care Management	Report of all members receiving care management services on an ongoing basis with the MCO.	Monthly
Section 7		
Section 7.3		
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
Monthly Premium Recoupment	Report produced for the MCOs for all members that received a premium payment in error.	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		
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		
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
Appendix E		
BabyNet Members	Report produced for the MCOs of members receiving BabyNet Services	Monthly
BabyNet Providers	Report produced for the MCOs of BabyNet Providers	Monthly

Model Attestation Letter

Attestation for Patient Centered Medical Home and Encounter Data

(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 3.7: 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

Section 3.18: 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. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 4.2: High Cost No Experience Drug Report: This form is utilized for requesting reimbursemet of High Cost No Experience pharmaceuticals as defined in the MCO policy and procedure guide and can be found at https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp If there are no records for a given month, submit the report with 'nothing to report' in the template. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 4.2: COVID-19 Vaccine Administration Report: This form is utilized for requesting reimbursemet of COVID-19 vaccine administration as defined in the MCO policy and procedure guide and can be found at https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp If there are no records for a given month, submit the report with 'nothing to report' in the template. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 5.4: Care Management Report: The MCO must submit the following report monthly to indicate its members currently receiving care management during the month. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 7.3: 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.

Office of Reporting

Date:

Report Requested by:

Report Title:

CCN	Check Date	Check Number	Individual Number	MBI Number	Premium Month	Provider Name	Provider Number	Total Claim Charge	Total Amt. Paid per Claim	Amount That Should Have Paid Initially	Difference Between Actual Amount That Should Have Paid and Original Payment	Paid Date	Premium Date	Recipient First Name	Recipient Last Name

Data Definitions

Descriptor	Definition
CCN	Claim Control Number, the unique 18 character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Check Date	The date that the check for the original premium payment was issued by SCDHHS.
Check Number	The number of the check for the original premium payment issued by SCDHHS.
Individual Number	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
MBI Number	The Medicare Beneficiary Indicator of the member. Medicare issued ID number.
Premium Month	The month that SCDHHS was making a premium payment for the member.
Provider Name	The name of the Managed Care Organization.
Provider Number	The Medicaid legacy ID of the Managed Care Organization.
Total Claim Charge	The total premium amount tied to the claim control number.
Total Amt. Paid per Claim	The total premium amount intially paid to the Managed Care Organization.
Amount That Should Have Paid Initially	The amount that should have been paid because the member was identified as retroactively eligible for Medicare services. This rate can be found in the MCO rate book and is reassessed on an annual basis.
Difference Between Actual Amount That Should Have Paid and Original Payment	The difference between the actual amount that should have paid and the original premium payment made for the member.
Paid Date	The Date that the original premium was paid to the MCO.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Recipient First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Recipient Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.

Section 7.3: Monthly Premium Recoupment: The MCO will receive this file on a monthly basis and will include a list of all members that received premium payment in error. It will have three sections and will include all members that passed away, received waiver or hospice services, or had duplicate Medicaid IDs. SCDHHS will perform premium voids that will appear on the 820 file for all members on this report to accurately pay premiums.

DECEASED MEMBERS
Office of Reporting
Date:
Report Requested by:
Report Title:

MEDICAID ID	FIRST NAME	MI	LAST NAME	DATE OF DEATH	PREMIUM DATE	RATE CELL	RATE DESCRIPTION	CLAIM ID	PROVIDER ID	PROVIDER NAME	CHECK DATE	PAID DATE	ADJ TYPE CODE	ADJUSTMENT DESCRIPTION	CAPITATION AMOUNT PAID	INTERNAL REASON CODE

Data Definitions Deceased Member Recoupment Reporting

Descriptor	Definition
Medicaid ID	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
MI	The middle initial of the Medicaid member that SCDHHS is performing the adjustment on.
Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Date of Death	The date that the member passed away.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Rate Cell	The three character premium descriptor for the premium amount originally paid to the MCO.
Rate Description	The definition of the three character premium descripto for the premium amount originally paid to the MCO.
Claim ID	Claim Control Number, the unique 18 character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Provider ID	The Medicaid legacy ID of the Managed Care Organization.
Provider Name	The name of the Managed Care Organization.
Check Date	The remittance date of the premium paid to the MCO.
Paid Date	The date that SCDHHS paid the premium to the MCO.
Adj Type Code	An internal code that defines the status of the premium. This value will be O in all instances on the report.
Adjustment Description	This is the definition of the Adj Type code. This value will be Original in all instances on the report.
Capitation Amount Paid	The total premium amount originally paid to the MCO.
Internal Reason Code	Utilized exclusively by SCDHHS for internal reporting.

Managed Care Members RetroTerminated Entering a Waiver or Hospice Services

Medicaid ID	First Name	Last Name	Premium Date	Rate Cell	Premium Month	Claim ID	Provider ID	Provider Name	Payment Date	Check Date	Amount Paid	Managed Care Term Date	Reason for Termination from Managed Care	Internal Reason Code

Data Definitions Waiver Hospice Termination Recoupment Report

Descriptor	Definition
Medicaid ID	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Rate Cell	The three character premium descriptor for the premium amount originally paid to the MCO.
Premium Month	The premium month. The month SCDHHS was making a premium payment for the member.
Claim ID	Claim Control Number, the unique 18 character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Provider ID	The Medicaid legacy ID of the Managed Care Organization.
Provider Name	The name of the Managed Care Organization.
Payment Date	The date that SCDHHS paid the premium to the MCO.
Check Date	The remittance date of the premium paid to the MCO.
Amount Paid	The total premium amount originally paid to the MCO.
Managed Care Term Date	The date that SCDHHS terminated the member from managed care enrollment due to waiver or hospice enrollment.
Reason for Termination from Managed Care	Field indicates wether the termination was due to WVR- waiver enrollment or HSP-Hospice enrollment.
Internal Reason Code	Utilized exclusively by SCDHHS for internal reporting.

Managed Care Members with Duplicate IDs and Premium Payments

Medicaid ID	First Name	Last Name	Premium Date	Rate Cell	Premium Month	Claim ID	Provider ID	Provider Name	Payment Date	Check Date	Amount Paid	Internal Reason Code

Data Definitions For Duplicate Member Recoupment Report

Descriptor	Definition
Medicaid ID	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Rate Cell	The three character premium descriptor for the premium amount originally paid to the MCO.
Premium Month	The premium month. The month SCDHHS was making a premium payment for the member.
Claim ID	Claim Control Number, the unique 18 character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Provider ID	The Medicaid legacy ID of the Managed Care Organization.
Provider Name	The name of the Managed Care Organization.
Payment Date	The date that SCDHHS paid the premium to the MCO.
Check Date	The remittance date of the premium paid to the MCO.
Amount Paid	The total premium amount originally paid to the MCO.
Internal Reason Code	Utilized exclusively by SCDHHS for internal reporting.

Section 7.3: Patient Centered Medical Home (PCMH)

Completing the PCMH Form:

There are four (4) worksheet tabs to this report. Worksheet one (1) is a review of the instructions. With respect to worksheets two (2) through four (4), please note that as of the 2017 version of NCQA's PCMH Recognition standards, NCQA no longer uses a leveling system for its PCMH Recognition program; however, some practices continue to be recognized under older versions of PCMH Recognition standards (e.g. the 2014 version of NCQA's PCMH Recognition standards. For purposes of the PCMH incentive, NCQA PCMH Recognition under the 2017 version of NCQA's standards is equivalent to a Level III under older versions of the PCMH Recognition standards.

Worksheet two (2) is utilized for level 1 PCMH providers, worksheet three (3) is for the level 2 PCMH providers, and worksheet four (4) is for both the level 3 PCMH providers and any providers recognized under NCQA PCMH Recognition standards as of 2017 or later.

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

The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 10.9: 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.

**The TPL Cost Avoidance, COB, Recoveries, and Casualty Cases reports can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

2) **TPL Cost Avoidance: TPL refers to other health insurance, not Medicare. Do not include Medicare provider file 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".

   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".

   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".

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".

   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".

   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".

4) **TPL Recoveries: TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report.** MCO report required for claims that were recovered during the month due to third party insurance coverage.

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
   Tab 2 – Closed Casualty Cases
   Tab 3 – Casualty Case Alerts

Section 11.1: MCO Provider Termination Monthly Report: MCO report required for monthly provider termination case reporting to program integrity can be found at the Program Integrity SharePoint site.

Section 13.1: Claims Payment Accuracy: 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 and the template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

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).

Encounter Edits Legacy and 277CA Encounter Edits:

Mapping details can be found in the 'Additional Resources' section at:

https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Appendix E: BabyNet Members: The MCO will receive this report on the first Monday of the month and incluides a list of BabyNet members.

PLAN_ID	PLAN_NAME	MID	DOB	PCAT	BNET_START	BNET_END	MCHM_ELIG	MCHM_INELIG	THERAPY_AUTH_FIRST_DOS	THERAPY_AUTH_LAST_DOS

DATA POINT	DEFINITION
PLAN_ID	The Medicaid legacy ID (six characters) of the managed care organization with the BabyNet member
PLAN_NAME	The name of the managed care organization with the BabyNet member
MID	The Medicaid ID of the member
DOB	The Date of Birth of the member
PCAT	The eligibility category of the member
BNET_START	The BabyNet eligibility start date
BNET_END	The BabyNet eligibility end date
MCHM_ELIG	Managed care eligibility eligibility start date
MCHM_INELIG	Managed care eligibility eligibility end date
THERAPY_AUTH_FIRST_DOS	The first date of service for BabyNet eligibility. This date is derived from the Individualized Family Service Plan (IFSP)
THERAPY_AUTH_LAST_DOS	The last date of service for BabyNet eligiblity. This date is derived from date of birth and Individualized Family Service Plan information

Appendix E: BabyNet Providers: The MCO will receive this report on the first Monday of the month and incluides a list of BabyNet billing and rendering providers.

Billing Provider Template:

AGENCY ID	AGENCY NAME	MMIS ID	MMIS MATCH TYPE	NPI	TAXONOMY	TAX ID	TAX ID TYPE	CONTRACT START DATE	CONTRACT END DATE	CONTACT PERSON	PHONE	FAX	EMAIL	BILLING CONTACT PERSON	BILLING PHONE	BILLING EMAIL

DATA POINT	DEFINITION
AGENCY ID	BabyNet defined Agency ID from Bridges care coordination system
AGENCY NAME	The name of the Provider organization/agency contracted with the BabyNet program
MMIS ID	The six digit Medicaid legacy provider ID of the agency/organization
MMIS MATCH TYPE	The search made between MMIS and Bridges to obtain the NPI and matching Medicaid legacy ID of the agency/organization
NPI	The ten digit national provider number of the contracted BabyNet agency/organization
TAXONOMY	The taxonomy code of the BabyNet agency/organization
TAX ID	The tax identification number of the organization
TAX ID TYPE	The type of tax identification number for the organization
CONTRACT START DATE	The start date of the contract between organization and BabyNet
CONTRACT END DATE	The end date of the contract between organization and BabyNet
CONTACT PERSON	Professional contact at the agency/organization
PHONE	Phone number of the BabyNet agency/organization
FAX	Fax number of the BabyNet agency/organization
EMAIL	Professional email contact at the BabyNet agency/organization
BILLING CONTACT PERSON	Professional billing contact at the BabyNet agency/organization
BILLING PHONE	Phone number of the billing office at the BabyNet agency/organization
BILLING EMAIL	Professional billing email address at the BabyNet agency/organization

Rendering Provider Template:

AGENCY ID	AGENCY NAME	AGENCY MMIS ID	AGENCY MMIS MATCH TYPE	USER ID	LAST NAME	FIRST NAME	MMIS ID	MMIS MATCH TYPE	NPI	TAXONOMY	DISCIPLINES	OTHER	PHONE	CELL PHONE	EMAIL	ADD DATE

DATA POINT	DEFINITION
AGENCY ID	BabyNet defined Agency ID from Bridges care coordination system
AGENCY NAME	The name of the Provider organization/agency contracted with the BabyNet program
AGENCY MMIS ID	The six digit Medicaid legacy provider ID of the agency/organization
AGENCY MMIS MATCH TYPE	The search made between MMIS and Bridges to obtain the NPI and matching Medicaid legacy ID of the agency/organization
USER ID	Concatenated individual rendering provider name
LAST NAME	The last name of the individual rendering provider
FIRST NAME	The first name of the individual rendering provider
MMIS ID	The individual rendering six digit Medicaid legacy provider ID
MMIS MATCH TYPE	The search made between MMIS and Bridges to obtain the NPI and matching Medicaid legacy ID of the individual rendering provider
NPI	The National Provider Identification (NPI) number of the individual rendering provider
TAXONOMY	The taxonomy code of the individual rendering provider
DISCIPLINES	The types of services offered by the indvidual rendering provider
OTHER	Any miscellaneous services offered by the individual rendering provider not described in DISCIPLINES
PHONE	Phone number of the agency/organization
CELL PHONE	Cell Phone number of the individual rendering provider
EMAIL	Email of the individual rendering provider
ADD DATE	The date the individual was added to the Bridges care coordination system.

REPORT REQUIREMENTS

QUARTERLY

Managed Care Report Name	Format	Report Timing
Quarterly Reporting Requirements		
Section 7		
Section 7.3		
MCO Withhold	Report template shared with the MCO to indicate quarterly withholding done to MCO's	Quarterly
Section 7.4		
FQHC RHC Wrap Payments Qtr	Current FQHC/RHC reports required for wrap payment process.	Quarterly
Section 9		
Section 9.1		
Member Grievance and Appeal Log	Grievance and Appeal reporting required of the MCO.	Quarterly
Section 9.2		
Provider Dispute Log	Provider dispute reporting required of the MCO.	Quarterly
Section 11		
Section 11.1		
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		
Section 13.1		
GME	Report detailing payment for Graduate Medical Education Providers and Institutions	Quarterly
Section 14		
Section 14.10		
EQI	Encounter Quality Initiative	Quarterly, Annually

Section 7.3: 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: FQHC/RHC Wrap Payments: Encounter/Claims Detail Data are provided in a separate file in MS Excel file format. All paid and denied claims for each FQHC/RHC contracting with the MCO during a specified quarter, by dates of service, are provided to SCDHHS via the Extranet, 60 days from the quarter's end date. The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 9.1: Member Grievance and Appeal Log: Grievance and Appeal reporting required of the MCO. Collected Monthly, Reported Quarterly.
The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 9.2: Provider Dispute Log: The MCO should submit this data compiling it monthly and then submitting to SCDHHS on a quarterly basis.
The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 11.6: Quarterly MCO Fraud and Abuse Report: The Quarterly Fraud and Abuse Report and Instructions can be found at the Program Integrity SharePoint site.

Section 13.1: GME Report Template: Report is utilized for reporting payments to teaching hospitals for DHHS calculation of the Graduate Medical Education reimbursement.
The Report Template can be found at: https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 14.10: Encounter Quality Initiative (EQI): MCOs are required to submit quarterly and annual Encounter Quality Initiative (EQI) reports to SCDHHS. The reporting schedule can be found in the MCO P&P. SCDHHS will provide instructions and templates for this report prior to their submission due dates.

REPORT REQUIREMENTS

BI-ANNUAL/ANNUAL

Managed Care Report Name	Format	Report Timing
Semi-Annual and Annual Reporting Requirements		
Section 2		
Section 2.1		
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 4		
Section 4.2		
Institution for Mental Disease (IMD)	Report provided to MCOs of members 21-64 with an IMD stay exceeding 15 days.	Annually
Section 6		
Section 6.3		
Provider Network	MCO report sent to SCDHHS reflecting MCOs entire provider network.	Bi-annually and as Requested
Section 7		
Section 7.4		
FQHC RHC Wrap Payments Annual	Current FQHC/RHC reports required for wrap payment process Annual Reconciliation.	Annually
Section 7.9		
Annual Audited Financial Statement	Should be the same report produced for the SC Department of Insurance.	Annually
Section 9		
Section 9.1		
Member Grievance and Appeal Log	Grievance and Appeal reporting required of the MCO.	Annually
Section 11		
Section 11.1		
Annual Strategic Plan	Strategic Plan Matrix can be found at PI SharePoint site.	Annually
Section 11.2		
Written Compliance Plan	Compliance Plan Matrix can be found at PI SharePoint site.	Annually
Section 14.10		
EQI	Encounter Quality Initiative	Quarterly, Annually
Section 15		
Section 15.1		
Population Assessment Report	NCQA defined	Annually
Section 15.3		
HEDIS and CAHPS	NCQA defined	Annually
Section 15.5		
APM	Alternative Payment Models	Annually

Section 2.1: 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 4.2: Institution for Mental Disease (IMD): For any member aged twenty one (21) through sixty four (64) receiving inpatient treatment in an Institution for Mental Disease (IMD) the length of stay must not exceed 15 days in any month. A report of these instances will be provided by SCDHHS to the MCOs.

Date:											
Report Requested by:											
Report Title:											
MCO Name:											
ANNUAL REPORT OF MEMBERS EXCEEDING 15 DAY STAYS IN IMD DURING THE FISCAL YEAR											
Individual Number	Recipient First Name	Recipient Last Name	Date of Birth	MCO Name	MCO Number	Premium Month Exceeding 15 day IMD Stay	Total IMD Days in Month	Original Total Premium Paid	Original Paid Date	Prorated Premium Amount for Month Exceeding 15 days	Difference Between Original Premium Payment and Prorated Amount That Should Have Been Paid

Data Definitions	
Descriptor	**Definition**
Individual Number	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
Recipient First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Recipient Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Date of Birth	The birthdate of the member. IMD 15 day stay limitations apply to any member between the ages of 21 and 64, evaluated as the first day of the month.
MCO Name	The name of the Managed Care Organization.
MCO Number	The Medicaid legacy ID of the Managed Care Organization.
Premium Month Exceeding 15 Day IMD Stay	The month that the recipient overstayed the 15 day requirement.
Total IMD Days in Month	The total number of IMD admitted days in month.
Original Total Premium Paid	The total premium amount intially paid to the Managed Care Organization.
Original Paid Date	The date that the original premium was paid to the MCO.
Prorated Premium Amount for Month Exceeding 15 days	The prorated premium amount that should have been paid because the member was identified as exceeding the 15 day stay in an IMD.
Difference Between Original Premium Payment and Prorated Amount That Should Have Been Paid	The difference between the actual amount that was paid and the prorated amount that should have paid for the member exceeding the 15 day IMD stay.

Section 6.3: Provider Network Report: This report must be submitted to SCDHHS biannually and as requested by the Department. Below are instructions and definitons on the submission of the entire network to the Department. The template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Plan specific information	Plan Name	Required by SC DHHS
	Time Period	
	Record Added or Modified by MCO	
Information specific to the provider	Medicaid Provider ID	
	NPI of Provider	
	First Name	NCQA Standards for Network Management Net 6 Physician and Hospital Directories (Element A: Physician Directory)
	Middle Name	
	Last Name	
	Gender	

	Primary Specialty (Code)	
	Primary Specialty (Description)	
	Secondary Specialty (Code)	
	Secondary Specialty (Description)	
	Taxonomy Code for Primary Specialty	Required by SC DHHS
	Taxonomy Code for Secondary Specialty	
	Group Name	
	Group Federal Employee ID Number	
	Provider License Number	
	Provider Email Address	
	Age Range Served	
Provider Hospital Affiliations (add more columns if needed)	Hospital Affiliation 1	
	Hospital Affiliation 2	
	Hospital Affiliation 3	
Provider Office Locations (Add a new record for each location)	Primary Location (Y/N)	
	Practice Name	NCQA Standards for Network Management Net 6 Physician and Hospital Directories (Element A: Physician Directory)
	Address	
	Suite/Building	
	City	
	State	
	ZIP	
	Phone Number	
Provider Office Information	Ownership of Practice (Hospital Name, Group Name, Organization Name, Sole Proprietorship)	Required by SC DHHS
	Provider Office Website Address	
	Average Number of Patients Seen Per Day	
	Accepting New Medicaid Patients	NCQA
	Office Hours (Sunday – Saturday)	
	Languages Spoken by Physician or Clinical Staff	
	Handicapped Accessible	
	Patient Centered Medical Home (PCMH) Recognition Level	Required by SC DHHS

Plan Name: Name of MCO submitting the data to SCDHHS
Time Period: When the report was generated by the reporting entity.
Record Added or Modified by MCO: If you change data in the record that was provided please indicate the following:

A- Record was added by the MCO and is a new record not in the original file.
M- Data element(s) on the record have been modified from the original file.
N- No change to the original file record.

For the initial submission please use A in all entries
Medicaid Provider ID: The six digit Medicaid ID issued to the provider by SCDHHS.
NPI of Provider: The national provider ID of the provider issued by NPPES.
First Name: The provider's first name.
Middle Name: The provider's middle name.
Last Name: The provider's last name.
Gender: The provider's gender, F-Female, M-Male

Primary Specialty (Code): The specialty code utilized by the MCO to describe the specialty of the individual provider.
Primary Specialty (Description): The description of the code utilized by the MCO to describe the provider specialty.
Secondary Specialty (Code): The specialty code utilized by the MCO to describe the secondary specialty of the provider.
Secondary Specialty (Description): The description of the code utilized by the MCO to describe the provider secondary specialty.
Taxonomy Code for Primary Specialty: The taxonomy code of the provider found at NPPES.
Taxonomy Code for Secondary Specialty: If applicable, the secondary specialty taxonomy code of the provider found at NPPES.
Group Name: The name of the provider that coincides with the Federal Employee ID number found in the next column.
Group Federal Employee ID Number: This field must be completed for all providers. If the provider being listed is an individual provider, the federal tax identification number of the practice he/she is associated with should be listed in this data field. If the individual is associated with multiple practices/groups the individual provider should be listed they are associated with. For example, if Dr. Smith is associated with ACME Providers 1 (tax ID:1234) and ACME Providers 2 (tax ID: 5678) Dr. Smith will be listed twice on the report once with tax ID:1234 and once with tax ID: 5678

For each provider practice/group, the MCO must indicate the federal tax identification number of the practice/group once.

Provider License Number: If applicable, the license number of the provider.
Provider Email Address: The email address of the provider.
Age Range Served: The age range of patients served by the provider expressed in years. For example, Joe's orthopedics would be expressed 0-100 if the practice serves any age member.
Hospital Affiliation 1: The primary hospital the individual provider is affiliated with and routinely admits Medicaid members to for treatment.
Hospital Affiliation 2: The secondary hospital the individual provider is affiliated with and admits Medicaid members to for treatment.
Hospital Affiliation 3: The tertiary hospital the individual provider is affiliated with and admits Medicaid members to for treatment.
Primary Location: Please indicate if the location listed is the provider's primary practice location. Values are Y/N, where Y indicates that this record is the primary location.
Practice Name: The name of the practice where the provider is located and may provide services.
Address: The physical address location of the practice where the provider is located and may provide services.
Suite/Building: If applicable, the suite or building number where the provider is located and may provide services.
City: The physical location city of the practice where the provider is located and may provide services.
State: The physical location state of the practice where the provider is located and may provide services.
Zip: The physical location zip code of the practice where the provider is located and may provide services.
Phone Number: The phone number of the primary location practice where the provider is located and may provide services.
Ownership of Practice: Please indicate who holds ownership of the practice. If the practice is owned by a hospital indicate the hospital that owns the practice. If owned by a group or an organization other than a hospital indicate the organization or group's name. If owned by a sole proprietor please indicate sole proprietor in this field. ***NOTE: a standardized list of hospitals has been provided. Please use this list to add hospital names.***
Provider Office Website Address: If the provider has a website, the website address of the provider.
Average Number of Patients Seen Per Day: The average number of patients seen per day. Please take the number of patients seen by the practice in the last month and divide that total by 20 (average number of business days in the month). For example, if the practice saw 700 patients over the past month the average patients seen per business day is 35. If the value expressed is fractional please truncate the fractional value.
Accepting New Medicaid Patients: Is the provider accepting new Medicaid patients. Please see the descriptions below that describe the type of new patient values.

This code indicates how PSI will accept Enrollments to the Provider

Value	Description	Allow Choice via			Patient Indicator
		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 not

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.

Office Hours (Sunday): These are the operating hours of the group. Please include any breaks for lunch in this field.
Office Hours (Monday): These are the operating hours of the group. Please include any breaks for lunch in this field.
Office Hours (Tuesday): These are the operating hours of the group. Please include any breaks for lunch in this field.
Office Hours (Wednesday): These are the operating hours of the group. Please include any breaks for lunch in this field.
Office Hours (Thursday): These are the operating hours of the group. Please include any breaks for lunch in this field.
Office Hours (Friday): These are the operating hours of the group. Please include any breaks for lunch in this field.
Office Hours (Saturday): These are the operating hours of the group. Please include any breaks for lunch in this field.
Languages Spoken by Provider or Staff: Indicate the languages spoken by the physician or their clinical staff. If left blank this indicates provider speaks English only. If the provider speaks several languages this must be represented by inserting all languages in this field separating each language spoken with a comma followed by a space and then the next language spoken (E.G.: SPA, ENG, FRE, POR, GER). Please see below for a list of codes.

DHHS	Code	Language		DHHS	Code	Language
S	SPA	Spanish		L	LAO	Laotian
M	MDR	Mandarin		N	HMN	Hmung
P	POR	Portuguese		O	Oth	Other
V	VIE	Vietnamese		Q	GER	German
H	HIN	Hindi		U	UKR	Ukranian
K	KOR	Korean		W	ARM	Armenian
C	CHI	Chinese		X	KHM	Khmer
G	GUJ	Gujarati		Y	YID	Yiddish
R	RUS	Russian		Z	GRE	Greek
A	ARA	Arabic		1	SMO	Samoan
T	TUR	Turkish		2	HAT	Haitian
B	POL	Polish		3	SGN	American Sign Language
D	PER	Persian		4	TGL	Tagalog
F	FRE	French		5	NED	Nederland
I	ITA	Italian		6	EGY	Egyptian
J	JPN	Japanese			ALBA	Albanian
	AFR	Afrikanns			AMH	Amharic
	BEN	Bengali			BUL	Bulgarian
	CAM	Cambodian			CAN	Cantonese
	CRE	Creole			CRO	Croatian
	CZEC	Czechoslovakian			DUTC	Dutch
	EST	Estonian			ETH	Ethopian
	FAN	Fante			FAR	Farsi
	GUI	Guiarati			HA	Hausa
	HEB	Hebrew			IBO	Ibo
	HUN	Hungarian			ICE	Iceland
	IND	Indian			INDO	Indonesian
	KAN	Kannada			LAT	Latino
	LEB	Lebanese			LIT	Lithuanian
	MAL	Malayalam			MALA	Malay
	MAR	Marathi			NE	Nepali
	NO	Norwegian			PASH	Pashtou
	PHIL	Phillipino			PUN	Punjabi
	ROM	Romanian			SER	Serbian
	SIN	Sindhi			SLOV	Slovakian
	SOMA	Somali			SWA	Swahili
	SWE	Swedish			TAI	Taiwanese
	TAM	Tamil			TEL	Telugu
	THAI	Thai			URDU	Urdu
	YOR	Yoruba			ZUL	Zulu

Handicap Accessible: Is the providers office handicap accessible, add Y for yes if it is handicap accessible, add N for No if it is not handicap accessible.

Patient Centered Medical Home (PCMH) Recognition Level: If the provider has PCMH recognition please indicate the level of recognition obtained by the provider through the National Committee for Quality Assurance (NCQA)

Hospital Addresses

KEY	HospitalName	ADDRESS	CITY	STATE	ZIP
1	ABBEVILLE AREA MEDICAL CENTER	420 THOMSON CIR	ABBEVILLE	SC	29620-5656
2	AIKEN REGIONAL MEDICAL CENTERS	302 UNIVERSITY PKWY	AIKEN	SC	29801-6302
3	ALLENDALE COUNTY HOSPITAL	1787 ALLENDALE FAIRFAX HWY	FAIRFAX	SC	29827-9133
4	ANMED HEALTH CANNON	123 WG ACKER DR	PICKENS	SC	29671-2739
5	ANMED HEALTH MEDICAL CENTER	800 N FANT ST	ANDERSON	SC	29621-5793
6	ANMED HEALTH WOMEN'S AND CHILDREN'S HOSPITAL	2000 E GREENVILLE ST	ANDERSON	SC	29621-1580
7	BAPTIST EASLEY HOSPITAL	200 FLEETWOOD DR	EASLEY	SC	29640-2099
8	BEAUFORT MEMORIAL HOSPITAL	955 RIBAUT RD	BEAUFORT	SC	29902-5454
9	BON SECOURS-ST FRANCIS XAVIER HOSPITAL	2095 HENRY TECKLENBURG DR	CHARLESTON	SC	29414-5734
10	CAROLINA PINES REGIONAL MEDICAL CENTER	1304 W BOBO NEWSOM HWY	HARTSVILLE	SC	29550-4399
11	CAROLINAS HOSPITAL SYSTEM	805 PAMPLICO HWY	FLORENCE	SC	29505-6050
12	CAROLINAS HOSPITAL SYSTEM CEDAR TOWER	121 E CEDAR ST	FLORENCE	SC	29506-2576
13	CAROLINAS HOSPITAL SYSTEM-MARION	2829 E HWY 76	MULLINS	SC	29574-6035
14	CHESTER REGIONAL MEDICAL CENTER	1 MEDICAL PARK DR	CHESTER	SC	29706-9776
15	COASTAL CAROLINA HOSPITAL	1000 MEDICAL CENTER DR	HARDEEVILLE	SC	29927-3446
16	COLLETON MEDICAL CENTER	501 ROBERTSON BLVD	WALTERBORO	SC	29488-5714
17	CONWAY HOSPITAL	300 SINGLETON RIDGE RD	CONWAY	SC	29526-9142
18	EAST COOPER MEDICAL CENTER	2000 HOSPITAL DR	MOUNT PLEASANT	SC	29464-3764
19	EDGEFIELD COUNTY HOSPITAL	300 RIDGE MEDICAL PLAZA RD, RIDGE MEDICAL PLAZA	EDGEFIELD	SC	29824-4525
20	FAIRFIELD MEMORIAL HOSPITAL	102 US HWY 321 BYP N	WINNSBORO	SC	29180-9251
21	GHS GREENVILLE MEMORIAL HOSPITAL	701 GROVE RD	GREENVILLE	SC	29605-5611
22	GHS GREER MEMORIAL HOSPITAL	830 S BUNCOMBE RD	GREER	SC	29650-2400
23	GHS HILLCREST MEMORIAL HOSPITAL	729 SE MAIN ST	SIMPSONVILLE	SC	29681-3280
24	GHS LAURENS COUNTY MEMORIAL HOSPITAL	22725 HWY 76 E	CLINTON	SC	29325-7527
25	GHS OCONEE MEMORIAL HOSPITAL	298 MEMORIAL DR	SENECA	SC	29672-9443
26	GHS PATEWOOD MEMORIAL HOSPITAL	175 PATEWOOD DR	GREENVILLE	SC	29615-3570
27	GRAND STRAND MEDICAL CENTER	809 82ND PKWY	MYRTLE BEACH	SC	29572-4611
28	HAMPTON REGIONAL MEDICAL CENTER	595 W CAROLINA AVE	VARNVILLE	SC	29944-4735
29	HILTON HEAD HOSPITAL	25 HOSPITAL CENTER BLVD	HILTON HEAD ISLAND	SC	29926-2738
30	KERSHAWHEALTH	1315 ROBERTS ST	CAMDEN	SC	29020-3737
31	LAKE CITY COMMUNITY HOSPITAL	258 N RON MCNAIR BLVD	LAKE CITY	SC	29560-2462
32	LEXINGTON MEDICAL CENTER	2720 SUNSET BLVD	WEST COLUMBIA	SC	29169-4810
33	MARY BLACK HEALTH SYSTEM - SPARTANBURG	1700 SKYLYN DR	SPARTANBURG	SC	29307-1061
34	MARY BLACK HEALTH SYSTEM-GAFFNEY	1530 N LIMESTONE ST	GAFFNEY	SC	29340-4738
35	MCCLEOD HEALTH CHERAW	711 CHESTERFIELD HWY	CHERAW	SC	29520-7002
36	MCLEOD HEALTH CLARENDON	10 E HOSPITAL ST	MANNING	SC	29102-3153
37	MCLEOD LORIS	3655 MITCHELL ST	LORIS	SC	29569-2844
38	MCLEOD MEDICAL CENTER DILLON	301 E JACKSON ST	DILLON	SC	29536-2509
39	MCLEOD MEDICAL CENTER-DARLINGTON	701 CASHUA FERRY RD	DARLINGTON	SC	29532-8488
40	MCLEOD REGIONAL MEDICAL CENTER OF THE PEE DEE	555 E CHEVES ST	FLORENCE	SC	29506-2617
41	MCLEOD SEACOAST	4000 HWY 9 E	LITTLE RIVER	SC	29566-7833
42	MOUNT PLEASANT HOSPITAL	3500 HWY 17 N	MOUNT PLEASANT	SC	29466-9123
43	MUSC MEDICAL CENTER	169 ASHLEY AVE	CHARLESTON	SC	29425-8905
44	NEWBERRY COUNTY MEMORIAL HOSPITAL	2669 KINARD ST	NEWBERRY	SC	29108-2932
45	PALMETTO HEALTH BAPTIST	1330 TAYLOR ST	COLUMBIA	SC	29220
46	PALMETTO HEALTH BAPTIST PARKRIDGE	400 PALMETTO HEALTH PKWY	COLUMBIA	SC	29212-1760
47	PALMETTO HEALTH RICHLAND	5 RICHLAND MEDICAL PARK DR	COLUMBIA	SC	29203-6897
48	PALMETTO HEALTH TUOMEY	129 N WASHINGTON ST	SUMTER	SC	29150-4983
49	PELHAM MEDICAL CENTER	250 WESTMORELAND RD	GREER	SC	29651-9013
50	PIEDMONT MEDICAL CENTER	222 S HERLONG AVE	ROCK HILL	SC	29732-1158
51	PROVIDENCE HEALTH	2435 FOREST DR	COLUMBIA	SC	29204-2098
52	PROVIDENCE HEALTH - NORTHEAST	120 GATEWAY CORPORATE BLVD	COLUMBIA	SC	29203-9611
53	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	3000 SAINT MATTHEWS RD	ORANGEBURG	SC	29118-1496
54	ROPER HOSPITAL	316 CALHOUN ST	CHARLESTON	SC	29401-1125
55	SELF REGIONAL HEALTHCARE	1325 SPRING ST	GREENWOOD	SC	29646-3875
56	SPARTANBURG MEDICAL CENTER	101 E WOOD ST	SPARTANBURG	SC	29303-3072
57	SPRINGS MEMORIAL HOSPITAL	800 W MEETING ST	LANCASTER	SC	29720-2298
58	ST FRANCIS-DOWNTOWN	1 SAINT FRANCIS DR	GREENVILLE	SC	29601-3999
59	ST FRANCIS-EASTSIDE	125 COMMONWEALTH DR	GREENVILLE	SC	29615-4812
60	SUMMERVILLE MEDICAL CENTER	295 MIDLAND PKWY	SUMMERVILLE	SC	29485-8104
61	TIDELANDS GEORGETOWN MEMORIAL HOSPITAL	606 BLACK RIVER RD	GEORGETOWN	SC	29440-3368
62	TIDELANDS WACCAMAW COMMUNITY HOSPITAL	4070 HWY 17 BYPASS	MURRELLS INLET	SC	29576-5033
63	TRIDENT MEDICAL CENTER	9330 MEDICAL PLAZA DR	N CHARLESTON	SC	29406-9104
64	UNION MEDICAL CENTER	322 W SOUTH ST	UNION	SC	29379-2839
65	WILLIAMSBURG REGIONAL HOSPITAL	500 NELSON BLVD	KINGSTREE	SC	29556-4027
66	ANMED HEALTH REHABILITATION HOSPITAL	1 SPRING BACK WAY	ANDERSON	SC	29621-2676
67	CAROLINA CENTER FOR BEHAVIORAL HEALTH	2700 E PHILLIPS RD	GREER	SC	29650-4815
68	CHILDREN'S HABILITATION CENTER	355 CEDAR SPRINGS RD	SPARTANBURG	SC	29302-4699
69	CITADEL INFIRMARY	171 MOULTRIE ST	CHARLESTON	SC	29409-0001
70	CONTINUECARE HOSPITAL AT PALMETTO HEALTH BAPTIST	1330 TAYLOR ST	COLUMBIA	SC	29220
71	CORRECT CARE OF SOUTH CAROLINA	7901 FARROW RD	COLUMBIA	SC	29203-3220
72	G WERBER BRYAN PSYCHIATRIC HOSPITAL	220 FAISON DR	COLUMBIA	SC	29203-3210
73	GHS NORTH GREENVILLE LONG TERM ACUTE CARE HOSPITAL	807 N MAIN ST	TRAVELERS REST	SC	29690-1598
74	GILLIAM PSYCHIATRIC HOSPITAL	4344 BROAD RIVER RD	COLUMBIA	SC	29210-4010
75	GREENWOOD REGIONAL REHABILITATION HOSPITAL	1530 PKWY	GREENWOOD	SC	29646-4027
76	HEALTHSOUTH REHABILITATION HOSPITAL OF CHARLESTON	9181 MEDCOM ST	CHARLESTON	SC	29406-9184
77	HEALTHSOUTH REHABILITATION HOSPITAL OF COLUMBIA	2935 COLONIAL DR	COLUMBIA	SC	29203-6811
78	HEALTHSOUTH REHABILITATION HOSPITAL OF FLORENCE	900 E CHEVES ST	FLORENCE	SC	29506-2704
79	HEALTHSOUTH REHABILITATION HOSPITAL OF ROCK HILL	1795 DR FRANK GASTON BLVD	ROCK HILL	SC	29732-1190
80	KIRKLAND CORRECTIONAL INSTITUTION INFIRMARY	4344 BROAD RIVER RD	COLUMBIA	SC	29210-4010
81	LEE CORRECTIONAL INSTITUTION INFIRMARY	1204 E CHURCH ST	BISHOPVILLE	SC	29010-2021
82	LIEBER CORRECTIONAL INSTITUTION INFIRMARY	136 WILBORN AVE	RIDGEVILLE	SC	29472-6351
83	LIGHTHOUSE BEHAVIORAL HEALTH HOSPITAL	152 WACCAMAW MEDICAL PARK DR	CONWAY	SC	29526-8901
84	MORRIS VILLAGE	610 FAISON DR	COLUMBIA	SC	29203-3218
85	PALMETTO LOWCOUNTRY BEHAVIORAL HEALTH	2777 SPEISSEGGER DR	NORTH CHARLESTON	SC	29405-8229
86	PATRICK B HARRIS PSYCHIATRIC HOSPITAL	130 HWY 252	ANDERSON	SC	29621-5054
87	REBOUND BEHAVIORAL HEALTH	134 E REBOUND RD	LANCASTER	SC	29720-7712
88	REGENCY HOSPITAL OF FLORENCE	121 E CEDAR ST 4TH & 5TH FLOORS	FLORENCE	SC	29506-2576
89	REGENCY HOSPITAL OF GREENVILLE	1 SAINT FRANCIS DR 4TH FLOOR	GREENVILLE	SC	29601-3999
90	SHERIFF AL CANNON DETENTION CENTER	3841 LEEDS AVE	N CHARLESTON	SC	29405-7469
91	SHRINERS' HOSPITAL FOR CHILDREN	950 W FARIS RD	GREENVILLE	SC	29605-4277
92	SOUTH CAROLINA VOCATIONAL REHABILITATION EVALUATION CENTER	1400 BOSTON AVE	WEST COLUMBIA	SC	29170-2138
93	SPARTANBURG HOSPITAL FOR RESTORATIVE CARE	389 SERPENTINE DR	SPARTANBURG	SC	29303-3074
94	SPARTANBURG REHABILITATION INSTITUTE	160 HAROLD FLEMING CT	SPARTANBURG	SC	29303-4226
95	SPRINGBROOK BEHAVIORAL HEALTH SYSTEM	1 HAVENWOOD LN	TRAVELERS REST	SC	29690-9447
96	THREE RIVERS BEHAVIORAL HEALTH	2900 SUNSET BLVD	WEST COLUMBIA	SC	29169-3422
97	TURBEVILLE CORRECTIONAL INSTITUTION INFIRMARY	1578 CLARENCE E COKER HWY	TURBEVILLE	SC	29162-9419
98	VIBRA HOSPITAL OF CHARLESTON	1200 HOSPITAL DR	MOUNT PLEASANT	SC	29464-3251
99	WILLIAM J MCCORD ADOLESCENT TREATMENT FACILITY	910 COOK RD	ORANGEBURG	SC	29118-2124
100	WILLOW LANE INFIRMARY	4650 BROAD RIVER RD	COLUMBIA	SC	29210-4016
101	WOMEN'S CENTER OF CAROLINAS HOSPITAL SYSTEM	1590 FREEDOM BLVD	FLORENCE	SC	29505-6042

As of October 2017
Pulled by Division of Integrated Health & Policy Research

Section 7.2: Medical Loss Ratio Calculation: In January of each year SCDHHS will provide instructions and templates for completing Medical Loss Ratio reports due to the department in April.

Section 7.4: FQHC/RHC Summary Annual Reconciliation: Please upload this report to the MCO's annual library in SharePoint. See the specific required format for this report at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 7.9: Annual Audited Financial Statement: The annual audited financial statement is due July 1st of each year. This statement should be the same report that is produced by each MCO for the South Carolina Department of Insurance and should comply with the documents and format listed below.

Regulation 69-70 – Annual Audited Financial Reporting Regulation

Section 1. Authority

This regulation is promulgated by the Director of Insurance (Director) of the South Carolina Department of Insurance (Department) pursuant to Section 38-3-110 of the South Carolina Code of Laws.

Section 2. Purpose and Scope

A. The purpose of this regulation is to improve the Department's surveillance of the financial condition of insurers, as defined in Section 3, by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) Communication of Internal Control Related Matters Noted in an Audit, and (3) Management's Report of Internal Control over Financial Reporting.

B. Every insurer shall be subject to this regulation. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificateholders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the Director makes a specific finding that compliance is necessary for the Director to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt.

C. Foreign or alien insurers filing the Audited Financial Report in another state, pursuant to that state's requirement for filing of Audited Financial Reports, which has been found by the Director to be substantially similar to the requirements herein, are exempt from Sections 4 through 13 of this regulation if:

(1) A copy of the Audited Financial Report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the Director in accordance with the filing dates specified in Sections 4, 11 and 12, respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

(2) A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the Director within the time specified in Section 10.

D. Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements and the Report is filed with the commissioner of the other state within the time specified.

E. This regulation shall not prohibit, preclude or in any way limit the Director from ordering or conducting or performing examinations of insurers under the rules and regulations of the Department and the practices and procedures of the Department.

Section 3. Definitions

A. The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

(1) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

(2) "Affiliate" of a specific person or a person "affiliated" with a specific person means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the specific person.

(3) "Audit Committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The Audit Committee of any entity that controls a group of insurers may be deemed to be the Audit Committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to Section 14(A)(5) for exercising this election. If an Audit Committee is not designated by the insurer, the insurer's entire board of directors shall constitute the Audit Committee.

(4) "Audited Financial Report" means and includes those items specified in Section 5 of this regulation.

(5) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

(6) "Independent board member" has the same meaning as described in Section 14(A)(3).

(7) "Insurer" includes any captive insurer, special purpose financial captives insurer, health maintenance organization, title insurer, fraternal organization, burial association, other association, corporation, partnership, society, order, individual, or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance or surety business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships, and corporations.

(8) "Group of insurers" means those licensed insurers included in the reporting requirements of Title 38, Chapter 21 - Insurance Holding Company Regulatory Act, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(9) "Internal control over financial reporting" means a process effected by an insurer's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and includes those policies and procedures that:

(a) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(b) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(c) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation.

(10) "SEC" means the United States Securities and Exchange Commission.

(11) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.) and the SEC's rules and regulations promulgated thereunder.

(12) "Section 404 Report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3(A)(1).

(13) "SOX Compliant Entity" means an entity that either is required to be compliant with, or

voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.): (i) the pre-approval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934) (15 USC Section 78a et seq.)); (ii) the Audit Committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934 (15 USC Section 78a et seq.)); and (iii) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Section 4. General Requirements Related to Filing and Extensions for Filing of Annual Audited Financial Reports and Audit Committee Appointment

A. All insurers shall have an annual audit by an independent certified public accountant and shall file an Audited Financial Report with the Director on or before June 1 for the year ended December 31 immediately preceding. The Director may require an insurer to file an Audited Financial Report earlier than June 1 with ninety days advance notice to the insurer.

B. Extensions of the June 1 filing date may be granted by the Director for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the Director of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the Director to make an informed decision with respect to the requested extension.

C. If an extension is granted in accordance with the provisions in Section 4B, a similar extension of thirty days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

D. Every insurer required to file an annual Audited Financial Report pursuant to this regulation shall designate a group of individuals as constituting its Audit Committee, as defined in Section 3. The Audit Committee of an entity that controls an insurer may be deemed to be the insurer's Audit Committee for purposes of this regulation at the election of the controlling person.

Section 5. Contents of Annual Audited Financial Report

A. The annual Audited Financial Report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flow, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the insurer's state of domicile.

B. The annual Audited Financial Report shall include the following:

(1) Report of independent certified public accountant.

(2) Balance sheet reporting admitted assets, liabilities, capital and surplus.

(3) Statement of operations.

(4) Statement of cash flow.

(5) Statement of changes in capital and surplus.

(6) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 38-13-80 of the South Carolina Code of Laws with a written description of the nature of these differences.

(7) The financial statements included in the Audited Financial Report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Director, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an Audited Financial Report, the comparative data may be omitted.

Section 6. Designation of Independent Certified Public Accountant

A. Each insurer required by this regulation to file an annual Audited Financial Report, within sixty days after becoming subject to the requirement, shall register with the Director in writing the name and address

of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this regulation. Insurers not retaining an independent certified public accountant on the effective date of this regulation shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first Audited Financial Report is to be filed.

B. The insurer shall obtain a letter from the accountant and file a copy with the Director stating that the accountant is aware of the provisions of the insurance code and the regulations of the insurance department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express an opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance department, specifying such exceptions as the accountant may believe appropriate.

C. If the accountant who was the insurer's accountant for the immediately preceding filed Audited Financial Report is dismissed or resigns, the insurer shall notify the Director within five business days of this event. The insurer shall also furnish the Director with a separate letter within ten business days of the above notification stating whether in the twenty-four months preceding the event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which, if not resolved to the satisfaction of the former accountant, would have caused the accountant to make reference to the subject matter of the disagreement in connection with the opinion. The disagreements required to be reported in response to this section include those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer also in writing shall request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for the disagreement; and the insurer shall furnish the responsive letter from the former accountant to the Director together with its own.

Section 7. Qualifications of Independent Certified Public Accountant

A. The Director shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

B. Except as otherwise provided in this regulation, the Director shall recognize an independent certified public accountant as qualified as long as the accountant conforms to the standards of the profession, as contained in the AICPA Code of Professional Conduct and the regulations of the South Carolina Board of Accountancy, or similar code.

C. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Chapter 27 of Title 38 of the South Carolina Code of Laws, the mediation or arbitration provisions shall operate at the option of the statutory successor.

D. The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same insurer or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the Director for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty days before the end of the calendar year. The Director may consider the following factors in determining if the relief should be granted:

(1) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(2) Premium volume of the insurer; or

(3) Number of jurisdictions in which the insurer transacts business.

E. The insurer shall file, with its annual statement filing, the approval for relief from Subsection D with

the states that it is licensed in or doing business in and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

F. The Director shall not recognize as a qualified independent certified public accountant or accept any annual Audited Financial Report prepared in whole or in part by any person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Section 1961 et seq., or any dishonest conduct or practices under federal or state law;

(2) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this regulation; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation.

G. The Director, pursuant to statute, may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual Audited Financial Report made pursuant to this regulation and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation.

H. The Director shall not recognize as a qualified independent certified public accountant or accept an annual Audited Financial Report prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(1) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(2) Financial information systems design and implementation;

(3) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(4) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

(a) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(b) The insurer has competent personnel (or engages a third-party actuary) to estimate the reserves for which management takes responsibility; and

(c) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(5) Internal audit outsourcing services;

(6) Management functions or human resources;

(7) Broker or dealer, investment adviser, or investment banking services;

(8) Legal services or expert services unrelated to the audit; or

(9) Any other services that the Director determines, by regulation, are impermissible.

I. In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit their own work, and cannot serve in an advocacy role for the insurer.

J. Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from Subsection H. The insurer shall file with the Director a written statement discussing the reasons why the insurer should be exempt from these provisions. An exemption may be granted if the Director finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer.

K. A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in Subsection H or that do not conflict with Subsection I, only if the activity is approved in advance by the Audit Committee, in accordance with Subsection L.

L. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be pre-approved by the Audit Committee. The pre-approval requirement is waived with respect to non-audit services if the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity or:

(1) The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;

(2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; and

(3) The services are promptly brought to the attention of the Audit Committee and approved prior to the completion of the audit by the Audit Committee or by one or more members of the Audit Committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the Audit Committee.

M. The Audit Committee may delegate to one or more designated members of the Audit Committee the authority to grant the pre-approvals required by Subsection L. The decisions of any member to whom this authority is delegated shall be presented to the full Audit Committee at each of its scheduled meetings.

N. The Director shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the Director for relief from the above requirement on the basis of unusual circumstances.

O. The insurer shall file, with its Annual Statement filing, the Director's letter granting relief from Subsection N with the states in which it is licensed or doing business and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 8. Consolidated or Combined Audits

A. An insurer may make written application to the Director for approval to include in its Audited Financial Report audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

(1) Amounts shown on the consolidated or combined Audited Financial Report shall be shown on the worksheet;

(2) Amounts for each insurer subject to this section shall be stated separately;

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis;

(4) Explanations of consolidating and eliminating entries shall be included; and

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual Statements of the insurers.

Section 9. Scope of Audit and Report of Independent Certified Public Accountant

Financial statements furnished pursuant to Section 5 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with Auditing (AU) Section 319 of the AICPA Professional Standards, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 16, the independent certified public accountant should consider (as that term is defined in Statements on Auditing Standards (SAS) No. 102 of the AICPA

Professional Standards, Defining Professional Requirements in Statements on Auditing Standards or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Section 10. Notification of Adverse Financial Condition

A. The insurer required to furnish the annual Audited Financial Report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its Audit Committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Director as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the South Carolina Code of Laws as of that date. An insurer that has received a report pursuant to this paragraph shall forward a copy of the report to the Director within five business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Director. If the independent certified public accountant fails to receive the evidence within the required five business day period, the independent certified public accountant shall furnish to the Director a copy of its report within the next five business days.

B. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with Subsection A.

C. If the accountant, subsequent to the date of the Audited Financial Report filed pursuant to this regulation, becomes aware of facts that might have affected his or her report, the Director notes the obligation of the accountant to take such action as prescribed in AU 561 of the AICPA Professional Standards, Subsequent Discovery of Facts Existing at the Date of the Auditor's Report.

Section 11. Communication of Internal Control Related Matters Noted in an Audit

A. In addition to the annual Audited Financial Report, each insurer shall furnish the Director with a written communication as to any unremediated material weaknesses in its Internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty days after the filing of the annual Audited Financial Report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined in SAS No. 112 of the AICPA Professional Standards, Communicating Internal Control Related Matters Identified in an Audit, or its replacement) as of December 31 immediately preceding (so as to coincide with the Audited Financial Report discussed in Section 4(A)) in the insurer's Internal control over financial reporting identified by the accountant during the course of the audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

B. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

C. The insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant. The information should be made available to the examiner conducting a financial examination for review and kept in a manner as to remain confidential.

Section 12. Accountant's Letter of Qualifications

A. The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual Audited Financial Report, a letter stating:

(1) That the accountant is independent with respect to the insurer and conforms to the standards of their profession as contained in the AICPA's Code of Professional Conduct and pronouncements of its Financial Accounting Standards Board and the South Carolina Board of Accountancy, or similar code;

(2) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within

this regulation shall be construed as prohibiting the accountant from utilizing such staff as deemed appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

(3) That the accountant understands the annual Audited Financial Report and that its opinion thereon will be filed in compliance with this regulation and that the Director will be relying on this information in the monitoring and regulation of the financial position of insurers;

(4) That the accountant consents to the requirements of Section 13 of this regulation and that the accountant consents and agrees to make available for review by the Director, or the Director's designee or appointed agent, the workpapers, as defined in Section 13;

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and

(6) A representation that the accountant is in compliance with the requirements of Section 7 of this regulation.

Section 13. Definition, Availability and Maintenance of Independent Certified Public Accountants Workpapers

A. Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of insurer documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

B. Every insurer required to file an Audited Financial Report pursuant to this regulation, shall require the accountant to make available for review by Department examiners, all workpapers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department or at any other reasonable place designated by the Director. The insurer shall require that the accountant retain the audit workpapers and communications until the Department has filed a report on examination covering the period of the audit but no longer than seven years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the Department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the department.

Section 14. Requirements for Audit Committees

A. This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

(1) The Audit Committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the Audited Financial Report or related work pursuant to this regulation. Each accountant shall report directly to the Audit Committee.

(2) Each member of the Audit Committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection (A)(5) of this Section and Section 3(A)(C).

(3) In order to be considered independent for purposes of this section, a member of the Audit Committee may not, other than in his or her capacity as a member of the Audit Committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the Audit Committee and be designated as independent for Audit Committee purposes, unless

they are an officer or employee of the insurer or one of its affiliates.

(4) If a member of the Audit Committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the Director, may remain an Audit Committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(5) To exercise the election of the controlling person to designate the Audit Committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Director by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(6) The Audit Committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit Committee in accordance with the requirements of SAS No. 114 of the AICPA Professional Standards, The Auditor's Communication with those Charged with Governance, or its replacement, including:

(a) All significant accounting policies and material permitted practices;

(b) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(c) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(7) If an insurer is a member of an insurance holding company system, the reports required by Subsection (A)(6) may be provided to the Audit Committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit Committee.

(8) The proportion of independent Audit Committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 - $300,000,000	Over $300,000,000 - $500,000,000	Over $500,000,000
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The Director has authority afforded by state law to require the insurer's board to enact improvements to the independence of the Audit Committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit Committees with at least a supermajority of independent Audit Committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

(9) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the Director for a waiver from the Section 14 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 14 with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 15. Conduct of Insurer in Connection with the Preparation of Required Reports and Documents

A. No director or officer of an insurer shall, directly or indirectly:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

C. For purposes of Subsection B, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the Director, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer's Audit Committee.

Section 16. Management's Report of Internal Control over Financial Reporting

A. Each insurer required to file an Audited Financial Report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or group of insurers' Internal Control Over Financial Reporting, as these terms are defined in Section 3. The report shall be filed with the Director along with the Communicating Internal Control Related Matters Identified in an Audit described under Section 11. Management's Report of Internal Control Over Financial Reporting shall be as of December 31 immediately preceding.

B. Notwithstanding the premium threshold in Subsection A, the Director may require an insurer to file Management's Report of Internal Control Over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in S.C. Code Ann. Sections 35-5-120, 38-9-150, 38-9-360, and 38-9-440.

C. An insurer or a group of insurers that is

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404;

(3) not directly subject to Section 404 but is a SOX compliant entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX compliant entity; may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section's requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (i) a Section 16 report, or (ii) the Section 404 Report and a Section 16 report for those internal controls that have a material impact on the preparation of the insurer's or group of

insurers' audited statutory financial statements not covered by the Section 404 Report.

D. Management's Report of Internal Control Over Financial Reporting shall include:

(1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(2) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management shall not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting;

(6) A statement regarding the inherent limitations of internal control systems; and

(7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection D, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(1) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

(2) Management's Report on Internal Control over Financial Reporting, required by Subsection A , and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Director.

Section 17. Exemptions

Upon written application of an insurer, the Director may grant an exemption from compliance with any provision or requirement of this regulation if the Director finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten days from a denial of an insurer's written request for an exemption from this regulation, the insurer may request in writing a hearing, pursuant to statute, on its application for an exemption. The hearing shall be held in accordance with the statutes of the Department pertaining to administrative hearing procedures.

Section 18. Canadian and British Companies

A. For Canadian and British insurers, the annual Audited Financial Report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

B. For such insurers, the letter required in Section 6B shall state that the accountant is aware of the requirements relating to the annual Audited Financial Report filed with the Director pursuant to Section 4 and shall affirm that the opinion expressed is in conformity with those requirements.

Section 19. Effective dates

A. Unless otherwise noted, the requirements of this regulation shall become effective for the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers not required

to file a report because its total written premium is below the threshold that subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file the report. Likewise, an insurer acquired in a business combination shall have two calendar years following the date of acquisition or combination to comply with the reporting requirements.

B. The requirements of Section 7D shall become effective for audits of the year beginning January 1, 2010 and thereafter.

C. The requirements of Section 14 shall become effective on January 1, 2010. An insurer or group of insurers that is not required to have independent Audit Committee members or only a majority of independent Audit Committee members (as opposed to a supermajority) because the total direct written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one calendar year following the date of acquisition or combination to comply with the independence requirements.

Section 20. Severability Provision

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

HEALTH MAINTENANCE ORGANIZATIONS

COMPANY NAME:_____**NAIC Company Code:**_____

Contact:_____**Telephone:**_____

REQUIRED FILINGS IN THE STATE OF:_____**Filings Made During the Year 2017**

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES* Domestic State	Domestic NAIC	Foreign State	(5) DUE DATE	(6) FORM SOURCE **	(7) APPLICABLE NOTES
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½"X14")	1	EO	xxx	3/1	NAIC	
	1.1	Printed Investment Schedule detail (Pages E01-E27)	1	EO	xxx	3/1	NAIC	
	2	Quarterly Financial Statement (8 ½" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	
		II. NAIC SUPPLEMENTS						
	10	Accident & Health Policy Experience Exhibit	1	EO	xxx	4/1	NAIC	
	11	Actuarial Opinion	1	EO	xxx	3/1	Company	
	12	Health Care Exhibit (Parts 1, 2 and 3) Supplement	1	EO	xxx	4/1	NAIC	
	13	Health Care Exhibit's Allocation Report Supplement	1	EO	xxx	4/1	NAIC	
	14	Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	
	15	Life Supplemental Data due March 1	1	EO	xxx	3/1	NAIC	
	16	Life Supp Statement non-guaranteed elements –Exh 5, Int. #3	1	EO	xxx	3/1	Company	
	17	Life Supp Statement on par/non-par policies – Exh 5 Int. 1&2	1	EO	xxx	3/1	Company	
	18	Life Supplemental Data due April 1	1	EO	xxx	4/1	NAIC	
	19	Long-term Care Experience Reporting Forms	1	EO	xxx	4/1	NAIC	
	20	Management Discussion & Analysis	1	EO	xxx	4/1	Company	
	21	Medicare Supplement Insurance Experience Exhibit	1	EO	xxx	3/1	NAIC	
	22	Medicare Part D Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
	23	Property/Casualty Supplement due March 1	1	EO	xxx	3/1	NAIC	
	24	Property/Casualty Supplement due April 1	1	EO	xxx	4/1	NAIC	
	25	Risk-Based Capital Report	1	EO	xxx	3/1	NAIC	
	26	Schedule SIS	1	N/A	N/A	3/1	NAIC	
	27	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	
		III. ELECTRONIC FILING REQUIREMENTS						
	50	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	51	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	52	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	
	53	Risk-Based Capital .PDF Filing	xxx	1	N/A	3/1	NAIC	
	54	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	55	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	56	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
	57	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	58	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
		IV. AUDIT/INTERNAL CONTROL RELATED REPORTS						
	71	Accountants Letter of Qualifications	1	EO	N/A	6/1	Company	T
	72	Audited Financial Reports	1	EO	xxx	6/1	Company	U
	73	Audited Financial Reports Exemption Affidavit	1	N/A	N/A	3/1	Company	V
	74	Communication of Internal Control Related Matters Noted in Audit	1	N/A	N/A	8/1	Company	W
	75	Independent CPA : Designation/Change/Qualifications	1	N/A	N/A	Within 5 business days	Company	X
	76	Management's Report of Internal Control Over Financial Reporting	1	N/A	N/A	8/1	Company	Y
	77	Notification of Adverse Financial Condition	1	N/A	N/A	Within 5 business days of	Company	Z
	78	Request for Exemption to File	1	N/A	N/A	3/1	Company	AA
	79	Request to File Consolidated Audited Annual Statements	1	N/A	N/A	12/1	Company	BB
	80	Relief from the five-year rotation requirement for lead audit partner	1	EO	1	3/1	Company	CC
	81	Relief from the one-year cooling off period for independent CPA	1	EO	1	3/1	Company	DD
	82	Relief from the Requirements for Audit Committees	1	EO	1	3/1	Company	EE
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance of Advertising. See 25A S.C. Code Ann. Regulation 69-17, Section 17. (Insurers Writing A&H, Only)	1	0	1	3/1	Company	O
	102	Filings Checklist (with Column 1 completed)	1	0	0	3/1	State	
	103	Holding Company Registration Statement	1	0	0	3/1	State	
	104	Premium Tax Electronic Filing	1	0	1	3/1	State	P
	105	SC Health Ins. Pool Assessment Base Reporting Form	1	0	1	3/1	State	Q
	106	State Filing Fees Electronic Filing	1	0	1	3/1	State	R
	107	Comprehensive Annual Analysis	1	0	0	3/15	State	N
	108	Comprehensive Quarterly Analysis	1	0	0	6/1, 9/1, 12/1	State	N
	109	Market Value of Securities Which are on Deposit With This Department.				**No longer required**		
	110	Membership by County in SC	1	0	1	3/1, 5/15, 8/15, 11/15	State	

	111	HMO Supplement Form 1122	1	0	1	3/1	State	
	112	Enterprise Risk Report (Form F)	1	0	0	3/1	State	

***If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).**

****If Form Source is NAIC, the form should be obtained from the appropriate vendor.**

*****For those states that have adopted the NAIC updated Holding Company Model Act, a Form F filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL:** http://www.naic.org/public_lead_state_report.htm

******For those states that have adopted the NAIC updated Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. Consistent with the Form B filing requirements, the ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL:** http://www.naic.org/public_lead_state_report.htm

		NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)	
	A	Required Filings Contact Person:	Chief Financial Analyst Michael Shull Financial Regulation & Solvency Division mshull@doi.sc.gov 803-737-6221 Premium Tax Form Questions: Sharon Waddell Tax Manager swaddell@doi.sc.gov 803-737-4910
	B	Mailing Address:	Physical Address: South Carolina Department of Insurance 1201 Main Street, Suite 1000 Columbia, SC 29201 Mailing Address: South Carolina Department of Insurance Post Office Box 100105 Columbia, South Carolina 29202-3105
	C	Mailing Address for Filing Fees:	N/A. Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx, and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions.
	D	Mailing Address for Premium Tax Payments:	N/A. Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx, and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions.
	E	Delivery Instructions:	All required filings must be physically received in the Department no later than the indicated due date. If the due date falls on a weekend or a holiday, the next business day will be considered the due date.
	F	Late Filings:	Companies will be fined for a late filing on a case-by-case basis.
	G	Original Signatures:	Original signatures are required on all required filings.
	H	Signature/Notarization/Certification:	Required annual statements must be verified by at least two of its principal officers, at least one of whom prepared or supervised the preparation of the annual statement. See S.C. Code Ann. Section 38-13-80(A).
	I	Amended Filings:	Amended items must be filed within 10 days of their amendment, along with an explanation of the amendments. The signature requirements for the original filing should be followed for any amendment.
	J	Exceptions from normal filings:	Foreign companies should supply a written copy of any exemption or extension received by its state of domicile at least 10 days prior to the filing due date to receive an exemption or extension from the Department. Domestic companies should apply for an exemption or extension at least fifteen days prior to the filing due date.
	K	Bar Codes (State or NAIC):	Required only for NAIC filings. Please follow the instructions in the NAIC Annual Statement Instructions.
	L	Signed Jurat:	Not required from foreign insurers.
	M	NONE Filings:	See NAIC Annual Statement Instructions.

	N	CAA and CQA	Domestics, only. The filings must be submitted electronically in Microsoft Word format to the Chief Financial Analyst via mshull@doi.sc.gov. A hard copy filing is not required.
	O	Special Filings:	Certificate of Compliance of Advertising (insurers writing A&H, only) pursuant to 25A S.C. Code Ann. Regulation 69-17, Section 17B. Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of these rules must file with the Department a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these rules and the Insurance Laws of this State as implemented and interpreted by these rules.
	P	Insurer Fee & Premium Tax Forms and Instructions:	Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx, and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions. Questions: Sharon Waddell, Tax Manager, swaddell@doi.sc.gov or 803-737-4910.
	Q	SC Health Ins. Pool Assessment Base Reporting Form:	The SC Health Insurance Pool Assessment Base Reporting Form will not be faxed. See "Attachments to State Filing Checklists."
	R	Filing Fees:	Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx, and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions. Questions: Sharon Waddell, Tax Manager, swaddell@doi.sc.gov or 803-737-4910.
	S	Actuarial Opinion Summary:	In addition to Statements of Actuarial Opinion filed with annual financial statements on or before March 1 the Actuarial Opinion Summary (AOS) is required by March 15. The AOS will be maintained as confidential by the Department pursuant to S.C. Code Ann. Section 38-13-160 (2002). The AOS must be prepared as prescribed by the instructions including but not limited to: • the actuary's range of reasonable estimates and/or point estimates for loss and loss adjustment expense reserves • the difference between the insurer's carried reserves and the point estimate and/or range of reasonable estimates • an explanation of any exceptional adverse development
	T	Accountants Letter of Qualifications:	See Section 12 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
	U	Audited Financial Reports:	See Section 4 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
	V	Audited Financial Reports - Exemptions Affidavit:	See Section 17 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists." Insurer must file (i.e., it is not automatically exempt) either: Premium and Policyholders or Certificateholders Exemption Affidavit or Financial or Organizational Hardship Exemption Affidavit which can be accessed under "Attachments to State Filing Checklists."
	W	Communication of Internal Control Related Matters Noted in Audit:	See Section 11 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
	X	Independent CPA: Designation/Change/ Qualifications:	See Sections 6 and 7 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
	Y	Management's Report of Internal Control Over Financial Reporting:	See Section 16 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."

	Z	Notification of Adverse Financial Condition:	See Section 10 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
	AA	Request for Exemption to File:	See V. above.
	BB	Request to File Consolidated Audited Annual Statements:	See Section 8 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
	CC	Relief from the five-year rotation requirement for lead audit partner	South Carolina only requires this report if a company has requested relief from its domiciliary state and does not intend to file its request electronically with the NAIC. For further guidance see Sections 7D & 7E of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklist" located on the Company Information Page of the SC Department of Insurance website.
	DD	Relief from the one-year cooling off period for independent CPA	South Carolina only requires this report if a company has requested relief from its domiciliary state and does not intend to file its request electronically with the NAIC. For further guidance see Sections 7N & 7O of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklist" located on the Company Information Page of the SC Department of Insurance website.
	EE	Relief from the Requirements for Audit Committees	South Carolina only requires this report if a company has requested relief from its domiciliary state and does not intend to file its request electronically with the NAIC. See Section 14(A) of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists" located on the Company Information Page of the SC Department of Insurance

General Instructions
For Companies to Use
Checklist

Please Note: **This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.**

Electronic Filing is intended to include filing via the Internet or filing via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) **(Checklist)**

Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) **(Line #)**

Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) **(Required Filings)**

Name of item or form to be filed.

The ***Annual Statement Electronic Filing*** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions.* This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The ***March .PDF Filing*** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The ***Risk-Based Capital Electronic Filing*** includes all risk-based capital data.

The ***Risk-Based Capital .PDF Filing*** is the .pdf file for risk-based capital data.

The ***Supplemental Electronic Filing*** includes all supplements due April 1, per the *Annual Statement Instructions.*

The ***Supplemental .PDF Filing*** is the .pdf file for all supplemental schedules and exhibits due April 1. The

Quarterly Statement Electronic Filing includes the complete quarterly statement data.

The ***Quarterly Statement .PDF Filing*** is the .pdf file for quarterly statement data.

The ***Combined Annual Statement Electronic Filing*** includes the required pages of the combined annual statement and the combined Insurance Expense Exhibit.

The ***Combined Annual Statement .PDF Filing*** is the .pdf file for the Combined annual statement data and the combined Insurance Expense Exhibit.

The ***June .PDF Filing*** is the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

Column (4) (Number of Copies)

Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (EX) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail. if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

Column (5) (Due Date)

Indicates the date on which the company must file the form.

Column (6) (Form Source)

This column contains one of three words: "NAIC," "State," or "Company," If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions. If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions.*.

Column (7) (Applicable Notes)

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

Section 9.1: Member Grievance and Appeal Log: Grievance and Appeal reporting required of the MCO. Collected Monthly, Reported Annually.
The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 11.1: Program Integrity Annual Strategic Plan:
The PI Annual Strategic Plan Matrix can be found at the Program Integrity SharePoint site.

Section 11.2: Program Integrity Written Compliance Plan:
The PI Compliance Plan Matrix for MCOs to complete can be found at the Program Integrity SharePoint site. This report should be uploaded directly to PI via the PI SharePoint site annually and whenever changes are required to the report.

Section 14.10: Encounter Quality Initiative (EQI) Report Template:
MCOs are required to submit an annual Encounter Quality Initiative (EQI) report to SCDHHS. The reporting schedule can be found in the MCO P&P. Annually SCDHHS will provide instructions and templates for this report in December each year.

Section 15.1: Population Assessment Report:
The MCO must submit annually to SCDHHS a population assessment report written as consistent with population assessment criteria set forth in NCQA's standards and guidelines for health plan accreditation. The population assessment should be sent as submitted to the MCO's quality committee. The assessment may be due at a date set by the MCO's quality committee, but no more than 14 months shall elapse between annual submissions of reports. The first population assessment shall be submitted no later than December 31, 2018. SCDHHS may request submission to SCDHHS other documentation that is also required for NCQA's health plan accreditation and will communicate with the MCO reasonable timeframes to correspond with creation of documentation, if needed.

Section 15.3: 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.

SOUTH CAROLINA Healthy Connections MEDICAID

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 15.5: Alternative Payment Model: This report should be utilized by the MCO's to reflect alternative payment model contracts.
The annual report should be submitted in the plans annual report folder on SharePoint with the following naming convention [PlanName]_APM CONTRACTING_RY [Two-Digit Reporting Year].xls. The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

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). SCDHHS prefers a complete, cumulative Non-Par provider 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 we request that you do not submit files on Saturdays or Sundays. There is a 5,000 record limit per file and a 15 file max per day (so 75,000 records per day max).

This file can also contain voids. You have up to 18 months from the date an encounter was accepted at SCDHHS to void it.

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 3rd Monday of each month.

XXXXXX.REVIEW.FILE (VIA C:D) & XXXXXX.REVIEWC.FILE (VIA C:D)
Monthly file for re-certification (XXXXXX.REVIEW.FILE) is prepared by the 5th of each month. The other (XXXXXX.REVIEWC.FILE) is created around the 17th of each month. The recertification files 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 – contains only currently active procedure codes
PROCEDRE.CODE – contains any and all procedure codes including both currently active procedure codes and previously active procedure codes. This is what you should be using to verify any procedure codes before using the PROC-CODE-EDIT-IND.

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.
An 820 transaction file is used. The 820 is sent from SCDHHS.
Refer to the SCDHHS companion guides at;
http://www.dhhs.state.sc.us/dhhsnew/hipaa/Companion%20Guides.asp

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		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
53.	Proc code modifier	3	145	147	C	A (HIC), B (DENT) – Procedure Code Modifier -Table 7 Z (UB92) - Type of Bill - Table7Z
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		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
71.	Paid Provider #	6	187	192	C	Provider Paid for the Services File # 4 and # 8 – Provider and Provider Group Affiliations
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		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
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	
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
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		
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
649	Online Member Enrollment
650	Auto Enrollment
651	Member Choice
652	Member Choice Change
653	Change Override
654	Health Plan Re-enrollment
655	Auto Enrolled - Other Famly in PCP
656	Newborn Auto- Mother's Plan
657	Member Change for Moral or Religious Reasons
658	Member Change to Same Plan as Family
660	Member Change Due to Poor Quality of Care
661	Health Plan Historic Enrollment
662	Member Reassigned - Service Not Provided
663	Member's New Choice During Annual Enrollment
664	Member Reassigned Due to Abuse or Fraudulent Utilization of Services
666	PCP Historic Enrollment
667	Auto Enrollment-PCP Only
668	Family Member Plan
669	Prior Member Plan

680	Duplicate Medicaid Number
688	Auto Enrollment - Other Members in Plan
689	Auto Enrolled- Past Case History
694	Member's New Choice During Deferred Annual Enrollment
891	Conversion Member Transferred to New Health Plan
892	Conversion Member Assigned to Different Plan
899	Mass Change Assignment

Disenrollment Reason Codes Used by Enrollment Broker

Code	Description
3	Member Ineligible for Medicaid
4	Member Eligible for Medicare
5	Member Pay Cat Inconsistent with Managed Care
6	Managed Care Provider Terminated
8	Member Has Private HMO Coverage
10	Provider No Longer Participates In PCCM
11	MHN Board Provider Terminated
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 C
37	Entering A Waiver Program
38	Entering Hospice
39	Not Able To Get The Medicines I Was Able To Get In Regular Med
40	Entering Nursing Home
41	Other (Requires Additional Note on Exact Reason)
42	No reason provided on enrollment form
53	Didn't Realize What I was Signing Up For
55	Member Changed from Medicaid to HCK

56	Member Changed from HCK to Medicaid
60	Member Died
61	Member Is Incarcerated
65	Member No Longer Meets Criteria to Participate in Managed Care
65	Member No Longer Meets Criteria to Participate in Managed Care
66	Member Fails to Follow the Rules of the Plan
67	Member's Behavior is Disruptive, Unruly, Abusive or Uncooperat
70	Member Placed Out of Home
75	Pharmacy Not Part of Network
80	Duplicate Medicaid Number
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
91	Conversion Member Disenrolled
92	Dual/Waiver Member Disenrolled
98	Mass Transfer

Non-Par 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	
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	
19.	TAXONOMY	10	199	208	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
20.	FILLER	25	209	233		
21.						

Special instruction:
Fields 1, 2, 3, 4(when applicable), 5, 6, 7, 8, 9, 10 (when applicable), 13, 14 and 17 are mandatory fields that must contain provider specific data. Provider data submission not containing this information will subject the MCOs to penalties.

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

For questions regarding MMIS tables, contact the SCDHHS Provider Support Center at **888-289-0709** or via email at **edig.ops-mcaid@bcbssc.com**

This support team specializes in issues related to EDI claims submittal and processing.

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
DMRNL	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
MCRHR	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

AUTW8	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 10/01/19

0 QA CONTROL HOLD
(Enroll Status is for providers that are in the process of confirming tax-id and or Social Security Information with the IRS prior to provider payments)
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