**Purpose:** In order to balance the principles of access and confidentiality, the Data Oversight Council has devised a classification scheme for the data elements collected under the authority of Section 44-6-170 as amended, Code of Laws of South Carolina, 1976. This classification scheme aims to promote the use of accurate health data, provide equal treatment of data requesters and data providers, expedite the release process and encourage the release of the broadest spectrum of data elements without compromising patient confidentiality and appropriate confidentiality for health care providers, insurers and facilities.

Public use data files contain individual patient-level data using encounter-level data elements; release of these files requires the completion of this application and a signed Data Use Agreement. However, the Revenue and Fiscal Affairs Office, Data Integration and Analysis Division (RFA) has permission to release aggregate customized reports based on encounter-level data without a signed agreement.

Certain data elements are classified as restricted. They can either directly, in combination with or indirectly, when linked with other databases, identify a patient, health care facility, health care professional or health care insurer. Access to these data elements may be gained by submitting the *Application for Restricted Data* for approval by the DOC for patient, health care facility, professional or insurer identifiable data.

**Part I: Requestor Information Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section A: Requestor**

|  |  |
| --- | --- |
| NamePrincipal Investigator: |  |
| TitlePrincipal Investigator: |  |
| Organization/Entity: |  |
| Street Address: |  |
| City, State, Zip: |  |
| Phone: |  |  | Fax: |  |  | Email: |  |
| *Alternate Contact:* |  |
| *Agency/Organization/Firm:* |  |
| *Phone:* |  |  | *Fax:* |  |  | *Email:* |  |

**Section B: Data Request**

|  |
| --- |
| Reason for Data Request:  |
|  |
|  |
| Specify Data File(s) Requested:[ ]  Inpatient[ ]  Emergency Department | [ ]  Outpatient Surgery [ ]  Imaging | [ ]  Home Health |
| Time Period for Data: |  |
| File format and type of media: |  |
| Selection Criteria**.** *Specify the variables and values to be used for record selection.* |
|  |
| Previous Data Requests. |
|  |
| Expected Products from Study. *List any reports, publications, presentations, websites, etc.*  |
|  |

**Part II: Inpatient Hospitalization Data Elements Request Form**

|  |
| --- |
| **Encounter-Level Data** |
| [ ]  Length of Stay | [ ]  DRG |
| [ ]  Day of the Week Admission | [ ]  APR-DRG Score |
| [ ]  Month of Admission | [ ]  APR-DRG Description |
| [ ]  Day of the Week Discharge | [ ]  Primary Expected Payer Classification *i.e., Medicare, Medicaid, Insurance, HMO, Self-Pay, Indigent, TriCare, Worker’s Compensation and Other* |
| [ ]  Month of Discharge |  |
| [ ]  Admission Source | [ ]  Charges by Summary Revenue Codes  |
| [ ]  Admission Type | [ ]  Total Charges  |
| [ ]  Time from Admission to Discharge | [ ]  Days in Special Units *i.e., ICU, CCU, etc.* |
| [ ]  Patient Age at Admission in Years *Five year groupings except less than 5 years, which is reported as “under one” for children under one year of age and “one to four” for children one to four years of age; over 84 years is reported in “85 and over” category)* |  |
|  | [ ]  Physician Specialty Code *As adopted by the AMA* |
| [ ]  Patient Gender | [ ]  Health Care Professional Classification *i.e., Attending, Other* |
| [ ]  Patient Race/Ethnicity |  |
| [ ]  County of Patient’s Residence |  |
| [ ]  Admitting Diagnosis | **Please select one (1) of the following hospital characteristics:** |
| [ ]  Present on Admission Indicator for All Diagnoses |  |
| [ ]  Diagnosis Codes | [ ]  Teaching Status of the Facility |
| [ ]  Procedure Codes | [ ]  Trauma Level |
| [ ]  Procedure Day (in relationship to Admission Date) | [ ]  Level of Perinatal Service |
| [ ]  Major Diagnostic Categories  | [ ]  Urban/Rural Status of Health Care Facility*Based on MSA, Non-MSA County Status* |
| [ ]  E-codes (ICD-9-CM) |  |
| [ ]  External Cause of Morbidity Codes (ICD-10-CM) | [ ]  Bed Size Based on Licensed Beds *100 beds or less, 101 – 299 beds, 300 or more beds* |
| [ ]  Patient Discharge Status |  |

**Part III: Emergency Department Data Elements Request Form**

|  |
| --- |
| **Encounter-Level Data** |
| [ ]  Day of the Week Admission | [ ]  Patient Discharge Status |
| [ ]  Month of Admission | [ ]  Charges by Summary Revenue Codes  |
| [ ]  Admission Source | [ ]  Total Charges  |
| [ ]  Admission Type | [ ]  Days in Special Units *i.e., ICU, CCU, etc.* |
| [ ]  Patient Age at Admission in Years *Five year groupings except less than 5 years, which is reported as “under one” for children under one year of age and “one to four” for children one to four years of age; over 84 years is reported in “85 and over” category)* |
| [ ]  Physician Specialty Code *As adopted by the AMA* |
| [ ]  Patient Gender | [ ]  Health Care Professional Classification *i.e., Attending, Other* |
| [ ]  Patient Race/Ethnicity |
| [ ]  County of Patient’s Residence |  |
| [ ]  Patient Reason for Visit | **Please select one (1) of the following hospital characteristics:** |
| [ ]  Diagnosis Codes |
| [ ]  Procedure Codes | [ ]  Teaching Status of the Facility |
| [ ]  E-codes (ICD-9-CM) | [ ]  Trauma Level |
| [ ]  External Cause of Morbidity Codes (ICD-10-CM) | [ ]  Level of Perinatal Service |
| [ ]  AHRQ Broad Level Diagnostic Categories | [ ]  Urban/Rural Status of Health Care Facility*Based on MSA, Non-MSA County Status* |
| [ ]  AHRQ Detailed Diagnostic Categories |
| [ ]  Primary Expected Payer Classification  *i.e., Medicare, Medicaid, Insurance, HMO, Self-Pay, Indigent, TriCare, Worker’s Compensation and Other* | [ ]  Bed Size Based on Licensed Beds *100 beds or less, 101 – 299 beds, 300 or more beds* |

**Part IV: Ambulatory Surgery, Imaging, and Other Services/Equipment Requiring a Certificate of Need**

|  |
| --- |
| **Encounter-Level Data** |
| [ ]  Day of the Week Admission | [ ]  Diagnosis Codes |
| [ ]  Month of Admission | [ ]  Procedure Codes |
| [ ]  Admission Source | [ ]  Primary Expected Payer Classification  *i.e., Medicare, Medicaid, Insurance, HMO, Self-Pay, Indigent, TriCare, Worker’s Compensation and Other* |
| [ ]  Admission Type |
| [ ]  Patient Age at Admission in Years *Five year groupings except less than 5 years, which is reported as “under one” for children under one year of age and “one to four” for children one to four years of age; over 84 years is reported in “85 and over” category)* | [ ]  Total Charges  |
| [ ]  Physician Specialty Code  *As adopted by the AMA* |
| [ ]  Patient Gender | [ ]  Health Care Professional Classification  *i.e., Attending, Other* |
| [ ]  Patient Race/Ethnicity |
| [ ]  County of Patient’s Residence | [ ]  RFA-assigned procedure classification code  |
| [ ]  Patient Reason for Visit | [ ]  Patient Discharge Status  |

**Part V: Home Health Data Elements Request Form**

**Note:** This file is based on an episode of care for a patient. An episode of care is defined as beginning with an admission date and ending when there has been thirty consecutive days without services.

|  |
| --- |
| **Encounter-Level Data** |
| [ ]  Number of Months in Episode | [ ]  Physical Therapy Services Number of Encounters (by month of service) |
| [ ]  Day of the Week Admission |
| [ ]  Month of Admission | [ ]  Occupational Therapy Services Number of Encounters (by month of service) |
| [ ]  Year of admission |
| [ ]  Day of the Week Discharge | [ ]  Speech Therapy Services Number of Encounters (by month of service) |
| [ ]  Month of Discharge |
| [ ]  Admission Source | [ ]  Respiratory Therapy Services Number of Encounters (by month of service) |
| [ ]  Admission Referral Source |
| [ ]  Patient Age at Admission in Years *Five year groupings except less than 5 years, which is reported as “under one” for children under one year of age and “one to four” for children one to four years of age; over 84 years is reported in “85 and over” category* | [ ]  Medical Social Services Number of Encounters (by month of service) |
| [ ]  Home Health Aide Services Number of Encounters (by month of service) |
| [ ]  Patient Gender | [ ]  Physician Specialty Code  *As adopted by the AMA* |
| [ ]  Patient Race/Ethnicity |
| [ ]  County of Patient’s Residence | [ ]  Total Charges  |
| [ ]  Diagnosis Codes  | [ ]  Patient Discharge Status |
| [ ]  Skilled Nursing Services Number of Encounters (by month of service) | [ ]  Primary Expected Payer Classification  *i.e., Medicare, Medicaid, Insurance, HMO, Self-Pay, Indigent, TriCare, Worker’s Compensation and Other* |

**Part VI: Data Use Agreement**

**Data Use Agreement for**

**Public Use, Encounter-Level Data**

Chapter 19, Statutory Authority: 1976 Code Section 44-6-170, Article 9, “Data Release For Medical EncounterData & Financial Reports.” requires the South Carolina Revenue and Fiscal Affairs Office (hereinafter referenced as RFA) to protect the identity of patients, health care providers and health care professionals represented in data collected under this statute. Any effort to determine the identity of any person, health care provider, health care professional, or private health care insurer or to use the data for any purpose other than analysis and aggregate statistical reporting violates this statute and the conditions of this data use agreement. By virtue of this agreement, the undersigned agrees that no attempt to identify or attempt to contact particular persons, health care providers, health care professionals or private health care providers will be made.

The undersigned assures the following with respect to RFA encounter-level data sets:

1. I will, at all times, comply and keep current with all federal, state, and local laws and regulations, including, but not limited to, laws and regulations protecting the confidentiality and security of individually identifiable health information and establishing certain privacy rights.
2. I will require others under my direct supervision, including any subcontractors, who use these data in the organization specified below to sign this Agreement; I will keep those signed agreements and make them available to RFA upon request. A violation of the Data Use Agreement will result in the surrender of the data and possible penalties as specified under South Carolina Codes of Laws Chapter 19, Statutory Authority: 1976 Code Section 44-6-180.
3. I will not allow others to, nor will I, attempt to identify or attempt to contact any person, health care facility, health care provider, or private insurer neither directly nor indirectly. Release of data that would directly or indirectly identify a person, health care facility, health care provider, or private insurer is a violation of Chapter 19, Statutory Authority: 1976 Code Section 44-6-170.
4. I will not allow others to, nor will I, release encounter-level data files or any part of them to any person outside the scope of the project described in this Data Use Agreement.
5. I will not allow others to, nor will I, attempt to link the encounter-level records of persons in this data set with personally identifiable records from any other source.
6. I will ensure that the organization specified below employs the appropriate safeguards to prevent the use or disclosure of the information other than as provided by this Data Use Agreement.
7. I acknowledge and accept the responsibility for protecting the confidentiality of patients when aggregate data have small cell sizes. It is a violation of this Data Use Agreement to directly or indirectly identify a patient.
8. I will report to RFA any use or disclosure of the encounter-level data not provided for by this Data Use Agreement of which the requestor becomes aware within 48 hours of discovery.
9. I will not allow others to, nor will I, release data in a report or for dissemination with a cell size of less than 5 without prior approval by the Data Oversight Council (hereinafter referenced as DOC).
10. I will not allow others to, nor will I, make statements indicating or suggesting that analyses and/or interpretations drawn are those of the data sources, RFA and its staff or the DOC.
11. I will not allow others to, nor will I, create an Internet, Intranet or other website without prior approval of the DOC.
12. In the event of a change in the principal investigator, a newly signed Data Use Agreement must be submitted to RFA within 30 days.
13. The data must remain solely with the original project entity. In the event of a proposed change of the project entity, a new application must be submitted to RFA within 30 days of the change.
14. No party shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney’s fees) which may arise out of any acts or failures to act by any other party, its employee or agents, in connection with the performance of services pursuant to this Agreement. This provision shall survive the termination of this Agreement for any claim arising during the term of the Agreement.These data are the property of RFA and must be surrendered upon direction of the DOC.
15. Releases of any aggregate data must contain the following statement:

**NOTICE: THIS INFORMATION IS FROM THE RECORDS OF THE REVENUE OF FISCAL AFFAIRS OFFICE, DATA INTEGRATION AND ANALYSIS DIVISION, SOUTH CAROLINA. OUR AUTHORIZATION TO RELEASE THIS INFORMATION DOES NOT IMPLY ENDORSEMENT OF THIS STUDY OR ITS FINDINGS BY EITHER THE REVENUE AND FISCAL AFFAIRS OFFICE OR THE DATA OVERSIGHT COUNCIL.**

Failure to comply with this Data Use Agreement will result in the surrender of data and may result in legal action as specified in Section 44-6-180, as amended, Code of Laws of South Carolina, 1976: **"**A person violating this section is guilty of a misdemeanor and, upon conviction, must be fined not more than five thousand dollars or imprisoned not more than one year, or both." Violators of this Agreement may also be subject to penalties under federal statutes that apply to these data.

|  |
| --- |
| **Principal Investigator** |
| Name and Title: |  |
| Organization: |  |
| Address:City, State, Zip |  |
| Street Address | City | State | Zip |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date  |

|  |
| --- |
| **CEO or Director** |
| Name and Title: |  |
| Organization: |  |
| Address:City, State, Zip |  |
| Street Address | City | State | Zip |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date  |

|  |
| --- |
| **IT Director**  |
| Name and Title: |  |
| Organization: |  |
| Address:City, State, Zip |  |
| Street Address | City | State | Zip |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date  |

|  |
| --- |
| **Notarization** |
| Subscribed and sworn to before me this |  | day of  |  | , 20 |  |
|  |
| Notary Public  |
| My commission expires on: |  |

(Notary Seal)

|  |
| --- |
| **List All Individuals with Access to the Data***(Please include employees, subcontractors, committee members, etc.)* |
| *Complete Organization and Address if different from that of the Principal Investigator.* |
| Name and Position: |  |
| Organization |  |
| Address:City, State, Zip |  |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date |
|  |  |
| Name and Position: |  |
| Organization |  |
| Address:City, State, Zip |  |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date |
|  |  |
| Name and Position: |  |
| Organization |  |
| Address:City, State, Zip |  |
|  | Street Address | City | State | Zip |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date |

|  |
| --- |
| **List All Individuals with Access to the Data - Continued***(Please include employees, subcontractors, committee members, etc.)* |
|  |
| Name and Position: |  |
| Organization |  |
| Address:City, State, Zip |  |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date |
|  |  |
| Name and Position: |  |
| Organization |  |
| Address:City, State, Zip |  |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date |
|  |  |
| Name and Position: |  |
| Organization |  |
| Address:City, State, Zip |  |
|  | Street Address | City | State | Zip |
| Phone: |  |  | Fax: |  |  | Email: |  |
| ***By signing this contract, I agree to comply with all the confidentiality requirements indicated in this document.*** |
|  |  |  |
| Signature |  | Date |