**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 an *Application for Encounter Data* and a signed Data Use Agreement. However, the 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 this application and signed Confidentiality Contracts for approval by the DOC for patient, health care facility, professional or insurer identifiable data.

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

**Section A: Requestor**

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

**Section B: Data Request**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title of Study: |  | | | |
| Reason for Data Request: | | | | |
|  | | | | |
| Previous Data Requests: | | | | |
|  | | | | |
|  | | | | |
| 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.* | | | | |
|  | | | | |
| **Files to be Linked.** *List all files that the data will be linked to and who will do the linkage.* | | | | |
|  | | | | |

|  |
| --- |
| **Approval Status of All Files to be Linked** |
|  |
| **Institutional Review Board / HIPAA Privacy Board**  *List any review boards that have or will review this request and if approved or denied; attach a copy of any review board approvals.* |
| Exempt  Exemption Category #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expedited  Expedited Research Category #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full Board  Does Not Constitute Human Subjects Research |

**Section C: Study Protocol and Project Activities**

|  |
| --- |
| *(Use additional pages if needed)* |

|  |
| --- |
| **Expected Products from Study.** *List any reports, publications, presentations, websites, etc.* |
|  |
| **Format and Level of Data to be Re-released.** |
|  |

**Section D: Security Measures**

|  |
| --- |
| **Data Security Methods***.* |
|  |
| **Patient Confidentiality Procedures.** |
|  |
| **Facility Confidentiality Procedures.** |
|  |
| **Date and Method by which Data will be Destroyed. Specify month, day, and year.** |
|  |

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

|  |  |
| --- | --- |
| **Section A: 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 II: Inpatient Hospitalization Data Elements Request Form**

|  |  |
| --- | --- |
| **Section B: Restricted-Level Data** | |
| **Restricted Data Elements Requested:** | **Reason for Request** |
| Admission Date |  |
| Admission Hour |  |
| Discharge Date |  |
| Discharge Hour |  |
| Patient Birth Date |  |
| Patient Age in Years |  |
| Medical Record Number |  |
| Patient Number (Facility-assigned) |  |
| Unique Patient Number (RFA-assigned) |  |
| Procedure Dates |  |
| Patient Zip Code (Digits 1-5) |  |
| Encrypted Carrier Codes |  |
| Health Care Professional ID  Attending  Other |  |
| Health Care Facility ID |  |

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

|  |  |
| --- | --- |
| **Section A: 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 III: Emergency Department Data Elements Request Form**

|  |  |
| --- | --- |
| **Section B: Restricted-Level Data** | |
| **Restricted Data Elements Requested:** | **Reason for Request** |
| Admission Date |  |
| Patient Birth Date |  |
| Patient Age in Years |  |
| Medical Record Number |  |
| Patient Number (Facility-assigned) |  |
| Unique Patient Number (RFA-assigned) |  |
| Procedure Dates |  |
| Patient Zip Code (Digits 1-5) |  |
| Encrypted Carrier Codes |  |
| Health Care Professional ID  Attending  Other |  |
| Health Care Facility ID |  |

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

|  |  |
| --- | --- |
| **Section A: Encounter-Level Data** | |
| Day of the Week Admission | Patient Reason for Visit |
| Month of Admission | Diagnosis Codes |
| Admission Source | Procedure Codes |
| Admission Type | Primary Expected Payer Classification  *i.e., Medicare, Medicaid, Insurance, HMO, Self-Pay, Indigent, TriCare, Worker’s Compensation and Other* |
| 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 | Diagnosis Codes |

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

|  |  |
| --- | --- |
| **Section B: Restricted-Level Data** | |
| **Restricted Data Elements Requested:** | **Reason for Request** |
| Admission Date |  |
| Patient Birth Date |  |
| Patient Age in Years |  |
| Patient Zip Code (Digits 1-5) |  |
| Unique Patient Number (RFA-assigned) |  |
| Medical Record Number |  |
| Health Care Professional ID |  |
| Health Care Facility ID |  |

**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.

|  |  |
| --- | --- |
| **Section A: Encounter-Level Data** | |
| Number of Months in Episode | Occupational Therapy Services Number of Encounters (by month of service) |
| Day of the Week Admission |
| Month of Admission | Speech Therapy Services Number of Encounters (by month of service) |
| Year of admission |
| Day of the Week Discharge | Respiratory Therapy Services Number of Encounters (by month of service) |
| Month of Discharge |
| Admission Source | Medical Social 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* | Home Health Aide Services Number of Encounters (by month of service) |
| Physician Specialty Code  *As adopted by the AMA* |
| Patient Gender |
| Patient Race/Ethnicity | Total Charges |
| County of Patient’s Residence | Primary Expected Payer Classification  *i.e., Medicare, Medicaid, Insurance, HMO, Self-Pay, Indigent, TriCare, Worker’s Compensation and Other* |
| Diagnosis Codes |
| Patient Discharge Status | Physical Therapy Services Number of Encounters (by month of service) |
| Skilled Nursing Services Number of Encounters (by month of service) |
|  |

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

|  |  |
| --- | --- |
| **Section B: Restricted-Level Data** | |
| **Restricted Data Elements Requested:** | **Reason for Request** |
| Date Service Span Begins |  |
| Date Service Span Ends |  |
| Patient Start of Care Date |  |
| Admission Date |  |
| Discharge Date |  |
| Patient Age in Years |  |
| Patient Date of Birth |  |
| Medical Record Number |  |
| Unique Patient Number (RFA Assigned) |  |
| Patient Zip Code (digits 1 - 5) |  |
| Skilled Nursing Services (by date of service) |  |
| Physical Therapy Services  (by date of service) |  |
| Occupational Therapy Services  (by date of service) |  |
| Speech Therapy Services  (by date of service) |  |
| Respiratory Therapy Services  (by date of service) |  |
| Medical Social Services  (by date of service) |  |
| Home Health Aide  (by date of service) |  |
| Charges by Type of Service  (nursing, therapies, home health aide and other) |  |
| Health Care Physician Provider |  |
| Home Health Care Facility ID |  |

**Part VI: Confidentiality Contract**

**Confidentiality Contract for**

**Encounter-Level Data Containing Restricted Data Elements**

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 particular persons, health care providers, health care professionals or private health care providers will be made.

I agree to the following confidentiality requirements related to the release of restricted data elements:

1. I will, at all times, keep current and comply 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 not allow others to, nor will I, use these data elements for purposes other than those specified in this application. Use of data elements for a research project other than the one described in this application will not be undertaken until a separate application form for that project has been submitted and approved under the procedures established in Final Regulations, Revenue and Fiscal Affairs Office, Chapter 19, Statutory Authority: 1976 Code Section 44-6-170, Article 9, “Data Release For Medical EncounterData & Financial Reports.”
3. I will not allow others to, nor will I, release any data elements or datasets to any person who is not under my direct supervision, except with the approval of the DOC.
4. I will not allow others to, nor will I, release the identity of any patient, directly or indirectly.
5. I will not allow others to, nor will I, conduct follow-back studies to patients without prior approval from the DOC.
6. I acknowledge and accept the responsibility that I will be held accountable for protecting the patient’s privacy if/when abstracting medical records. Any violation of patient’s privacy is subject to the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996, as amended, as well as forfeiture of all data and legal actions specified in Section 44-6-180, as amended, Code of Laws of South Carolina.
7. I will not allow others to, nor will I, use these data to identify any health care facility, professional and/or private insurer without prior approval by the DOC.
8. I will report to RFA any use or disclosure of the encounter-level data not provided for by this confidentiality contract of which the requestor becomes aware within 48 hours of discovery.
9. I will not allow others to, nor will I, publish, either written text or electronic text, disseminate, communicate or otherwise release health care facility, professional and/or private insurer identifiable data without prior approval by the DOC and review and comment by the identified parties*.*
10. I will not allow others to, nor will I, link these data to other person or encounter-level data without prior approval by the DOC.
11. I will not allow others to, nor will I, link these data to other health care facility, professional and/or private insurer level data without prior approval by the DOC.
12. I will not allow others to, nor will I, create an Internet, Intranet or other website using these data without prior approval of the DOC.
13. 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 Contract to directly or indirectly identify a patient, in data analyses, reports, publications, or any other forms, either electronic or written.
14. 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).
15. 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. The safeguards used for the storage of these data are included with this application.
16. A full disclosure of how these data are to be released, publish and/or disseminated, either written or electronic form, has been included in application. Release, publication and/or and other dissemination of data other than as described in this application will not be undertaken until a separate application form for that release, publication and any other dissemination means has been submitted and approved under the procedures established in Final Regulations, Revenue and Fiscal Affairs Office, Chapter 19, Statutory Authority: 1976 Code Section 44-6-170, Article 9, “Data Release For Medical EncounterData & Financial Reports.”
17. Internal reports created during the project containing restricted data must be marked “Confidential Not For Release”.
18. The original raw data elements and any copies will be destroyed or returned to RFA upon completion of the research project, as specified in the application. Aggregate data and reports based on restricted data shall be stored under appropriate security measures. The Principal Investigator will notify RFA via a certified letter detailing the destruction or return of these data.
19. The data must remain solely with the original project entity. A new application must be submitted and approved by the DOC in the event of a proposed change of the project entity.
20. In the event of a change in the principal investigator, a newly signed Confidentiality Contract must be submitted to RFA within 30 days.
21. 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 Contract. This provision shall survive the termination of this Contract for any claim arising during the term of the Contract.
22. These data are the property of RFAand must be surrendered upon direction of the DOC.
23. Approval by the DOC for the release of data is not equivalent to endorsement of the project.
24. All releases of data must contain the following statement:

**NOTICE: THIS INFORMATION IS FROM THE RECORDS OF THE SOUTH CAROLINA REVENUE AND FISCAL AFFAIRS OFFICE, DATA INTEGRATION AND ANALYSIS DIVISION. 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 Confidentiality Contract 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 Contract 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 | | | | | | |