# South Carolina Department of Insurance

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## BULLETIN NUMBER 2002-02

(Issued upon March 4, 2002)

To: All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina, All South Carolina Licensed Health Maintenance Organizations (HMOs), All South Carolina Certified Private Review Agents and All Other Interested Parties

From: Ernst N. Csiszar
Director

Re: Question and Answer Bulletin Under the Health Carrier External Review Act

I. PURPOSE

The purpose of this Bulletin is to provide guidance with respect to a number of recently asked industry and Independent Review Organization (IRO) questions concerning the implementation of the South Carolina Health Carrier External Review Act.

The South Carolina Department of Insurance (the Department) may periodically issue similar bulletins in question-and-answer format. All interested parties are encouraged to submit their questions to: Ann V. Bishop, Research and Compliance Analyst, South Carolina Department of Insurance, P.O. Box 100105, Columbia, South Carolina 29202-3105 or e-mail address abishop@doi.state.sc.us. All frequently asked questions will be answered by bulletin. All other questions will be individually responded to in writing by Department staff.

II. QUESTIONS AND ANSWERS

A. GENERAL QUESTIONS

1) QUESTION: If a clinical peer reviewer reviews a case at any time prior to the external review, would he/she be able to conduct the external review?
ANSWER: No. This would violate the conflict of interest provisions set forth in Section 38-71-2010 (D).

2) QUESTION: If an IRO is not on the list approved by the Department, may it be used to conduct an external review?
ANSWER: No. It may not be used to conduct an external review under the Health Carrier External Review Act. However, it may still be used to conduct any internal review or appeal of the health carrier.

3) QUESTION: If an IRO is owned by a holding company, which owns a healthplan, may it be approved to conduct external reviews?
ANSWER: No. This would violate the conflict of interest provisions set forth in Section 38-71-2010 (C).

4) QUESTION: Our company uses a network of licensed, board-certified physicians specializing in many areas as its providers of actual external reviews. Many of those physicians are contracted network providers for licensed health plans. Is this considered a conflict of interest?
ANSWER: The clinical peer reviewer may not have a material professional, familial, or financial conflict of interest with the health carrier. Refer to Section 38-71-2010 (D).

5) QUESTION: Can an IRO decline a request from a health carrier to conduct an external review?
ANSWER: Yes. An IRO may decline a request from a health carrier to conduct an external review for a variety of reasons including: the request did not involve a determination of medical necessity or experimental or investigational treatment; a conflict of interest exists; or the IRO is unable to find an appropriate reviewer.

6) QUESTION: Is a panel of reviewers needed in all external reviews?
ANSWER: No. Sections 38-71-1970 and 38-71-1980 require a panel to be used for experimental or investigational cases only.

7) QUESTION: If a panel is required, is it necessary to use all physicians meeting the credentials specified by the law, or is just one physician adequate?
ANSWER: All members of the panel must meet the credentialing requirements specified by law. However, the law does not require all members of the panel to be physicians.

8) QUESTION: Can one physician, solely, review an experimental or investigational case?
ANSWER: No. Sections 38-71-1970 and 38-71-1980 require a "panel" to be used for experimental or investigational cases.

9) QUESTION: May a single reviewer with specialty in the treatment or service under review and meeting the other credentialing requirements of the law review a case for medical necessity?
ANSWER: Yes. However, Sections 38-71-1970 and 38-71-1980 require a "panel" to be used for experimental or investigational cases.

10) QUESTION: Are partial decisions allowed?
ANSWER: No. The IRO must provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination. Refer to Sections 38-71-1970(H)(1) and 38-71-1980(F)(1).

11) QUESTION: If the patient has no financial liability in a retrospective review determination, is the retrospective denial subject to the provisions of the Health Carrier External Review Act?
ANSWER: No. Refer to Section 38-71-1950.

12) QUESTION: In the Health Carrier External Review Act, "health benefit plan" is defined in Section 38-71-1920(9)(*i*)(i) to exclude limited-scope dental benefits if offered separately. Is a dental-only plan issued by a PPO or indemnity insurer considered a limited-scope dental plan?
ANSWER: Limited-scope dental benefits are excluded from the definition of "health benefit plan" if they are provided under a separate policy, certificate, or contract of insurance or are not otherwise an integral part of the plan. For this purpose, limited-scope dental coverage typically provides benefits for non-medical services such as routine dental cleanings, x-rays and other preventive procedures. Such coverage may also provide discounts on the cost of common dental procedures such as fillings, root canals, crowns, full or partial plates or orthodontic services. Limited-scope dental coverage typically does not provide benefits for medical services, such as those procedures associated with oral cancer or with a mouth injury that results in broken, displaced or lost teeth.

13) QUESTION: Does this exclusion mean that dental-only plans are not covered by the Health Carrier External Review Act?
ANSWER: Dental-only plans are not covered by the Health Carrier External Review Act if they meet the requirements set forth in the answer to Question 14 of this Bulletin.

14) QUESTION: Does the Health Carrier External Review Act apply to the administrative services performed on behalf of a self-funded plan subject to the Employee Retirement Income Security Act (ERISA) of 1974?
ANSWER: No. Refer to Section 38-71-1930(B).

15) QUESTION: When must a health carrier notify the covered person in writing of his/her right to request an external review?

ANSWER: At the time the health carrier sends written notice of an adverse determination or a final adverse determination. Refer to Section 38-71-1940.

16) QUESTION: Must the notices required under Section 38-71-1940 be sent at the time of any noncertification?
ANSWER: Yes, if the noncertification is an adverse determination or a final adverse determination as defined under Section 38-71-1920.

17) QUESTION: Must notices required under Section 38-71-1940 be sent at the time of any administrative denials?
ANSWER: No, if the administrative denial is not an adverse determination or final adverse determination as defined under Section 38-71-1920.

18) QUESTION: When is a person presumed to have received notice of an adverse determination or final adverse determination?
ANSWER: The Health Carrier External Review Act does not specifically provide for presumption of receipt of the notice.

19) QUESTION: Section 38-71-1940 states that the health carrier shall notify the covered person in writing of the right to request an external review. If a private

review agent sent the notice for the health carrier, would this meet the requirement set forth in Section 38-71-1940?

ANSWER: Yes. The health carrier may delegate the responsibility of sending the notice to a private review agent; however, the health carrier is responsible for making sure the notice is sent and is ultimately held accountable.

B. REPORTING FORMS:

1) QUESTION: If a health carrier uses the notice forms promulgated by the Department to satisfy the requirements of Section 38-71-1940, must these forms be filed with the Department for approval?

ANSWER: No. A health carrier that uses the standardized notices will be deemed to have complied with the requirements of this section. However, a carrier that wishes to use a different notice must file that form for approval.

2) QUESTION: What does a "type of coverage" referenced in the Health Benefit Plan External Review Reporting Form mean?

ANSWER: A service or treatment that is the subject of external review.

3) QUESTION: If an IRO does not perform any reviews during a calendar year, must the reporting forms still be submitted to the Department before March 1 of each year?

ANSWER: No.

4) QUESTION: Our company has operating authority to transact A&H insurance in South Carolina, but we do not have any active filings or business currently in your state. In addition, we have no plans to start writing this business. Does our company have to file an Independent Review Organization External Review Reporting Form (Bulletin 2001-4, Appendix C) or Health Carrier External Review Reporting Form (Bulletin 2001-4, Appendix D)?

ANSWER: If your company does not meet the definition of a health carrier or an IRO as defined in Section 38-71-1920(13) and (14), you are not required to file Bulletin 2001-4, Appendixes C or D, respectively.

5) QUESTION: Would a health carrier need to provide the annual report if no external reviews were requested during the year?

ANSWER: No.

6) QUESTION: Since the law goes into effect January 1, 2002, when must Bulletin 2001-4, Appendixes C and D first be filed?

ANSWER: March 1, 2003