

South Carolina External Claim Review Information Packet

Please read this packet carefully. This packet contains important information about how to request an External Claim Review in the State of South Carolina.

I. External Review

A. Eligibility

You can have an external review only if you meet the following items:

1. The service or payment for service was denied, reduced or terminated because:
 - the service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or
 - the service was experimental or investigational and involves a life-threatening or seriously disabling condition;
2. The amount payable for covered benefits is at least \$500, and
3. You have completed your insured's administrative rights of appeal.
 - You do not have to complete the internal appeals process if:
 - a. Your physician or treating provider has certified in writing that you have a serious medical condition;
 - b. The service is experimental or investigational and your physician or treating provider has provided the required certifications;
 - c. The insurer has not issued a written decision within the time frames set forth in the insurer's administrative rights of appeal process. It must have received all the information from you that it needs to complete that process. You or your authorized representative must not have agreed to a delay; or
 - d. The insurer agrees to waive the administrative rights of appeal process.

You always have to complete the administrative rights of appeal process if you have already received the service.

B. Types of External Review

There are two types of external reviews. The first is the standard external review. The second is the expedited external review. Expedited means "done more quickly." You will find the procedures for requesting each type of review below. A list of helpful terms may be found at the end of this notice.

1. Standard External Review

You have only 60 days to ask for a standard external review. Your 60 days start when you receive written notice of denial from the insurer.

First, you or someone acting for you must:

- Notify the insurer that you are asking for a standard external review. You must do this in writing;
- If your insurer said the treatment was "experimental" or "investigational," enclose a letter or certificate from your physician or treating provider. See I.C. Requirements for Physician's Certificate in this section; and
- Enclose a signed Medical Records Release form. You may request a copy of this form from the insurer. This allows your insurer to give your records to the IRO.

Second, your insurer must:

- Assign your request to an IRO;
- Send the IRO copies of the information it used to deny the service;
- Send you a notice that it took these actions;
- Or tell you why you will not get an external review. If you have any questions, contact the South Carolina Department of Insurance.

Your insurer must do all these things within five working days of receiving your request.

Third, within five working days of receiving your case, the IRO must:

- Decide if it has all the information it needs to review the case.
- Notify you if it needs more information. The IRO will tell you exactly what it needs. You must return this information to the IRO. You have seven working days after you receive the notice from the IRO to do this.

The IRO must notify you and the insurer within 45 days of its decision.

2. Expedited External Review

You have only 15 days to ask for an expedited external review. Your 15 days start when you receive written notice of denial from the insurer. You can have an expedited external review if:

- your physician or treating provider certifies that you have a serious medical condition which requires immediate treatment; or
- you received emergency medical care, have not been discharged from a facility, and may be held financially responsible for the emergency medical care.

First, you or someone acting for you must:

- Notify the insurer that you are asking for an expedited external review. You must do this in writing;
- Enclose a letter or certificate from your physician or treating provider. This letter or certificate must state that you have a serious medical condition;
- If your insurer said the treatment was “experimental” or “investigational,” your physician or treating provider has to provide more information. See I.C. Requirements for Physician’s Certificate in this section; and
- Enclose a signed Medical Records Release form. You may request a copy of this form from the insurer. This allows your insurer to give your records to the IRO.

Second, your insurer must:

- Assign your request to an IRO;
- Send the IRO copies of the information it used to deny the service;
- Send you a notice that it took these actions;
- Or tell you why you will not get an external review. If you have any questions, contact the South Carolina Department of Insurance.

Your insurer must do all of these things as quickly as possible.

The IRO must notify you and the insurer within three working days of its decision.

3. Understanding the Results of the Review

If the IRO finds in your favor, your insurer must approve the covered benefit. If the IRO does not find in your favor, you cannot request another review for the same denial.

C. Requirements for Physician’s Certificate

Give this to your physician or treating provider if:

- You have a serious medical condition; or
- The insurer denied the service or payment for service because it was experimental or investigational.

The information below tells your physician or treating provider what must be included on this certificate. It also tells when the certificate is needed. The certificate must be sent to your insurer.

1. Standard External Review

If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from the covered person’s physician or treating provider who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person’s condition and state that:

- (a) the covered person has a life-threatening disease or seriously disabling condition; and
- (b) at least one of the following situations is applicable:
 - (i) standard health care services or treatments have not been effective in improving the condition of the covered person;
 - (ii) standard health care services or treatments are not medically appropriate for the covered person; or
 - (iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the health carrier; and
- (c) medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is more beneficial to the covered person than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

2. Expedited External Review

- Your physician or treating provider must certify that your health condition or illness requires immediate medical attention, where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place your health in serious jeopardy.
- If your insurer said the treatment was experimental or investigational, the physician or treating provider must give an additional certification. This certification must be from the covered person's physician or treating provider who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person's condition and state that:
 - (a) the covered person has a life-threatening disease or seriously disabling condition; and
 - (b) at least one of the following situations is applicable:
 - (i) standard health care services or treatments have not been effective in improving the condition of the covered person;
 - (ii) standard health care services or treatments are not medically appropriate for the covered person; or
 - (iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the insurer; and
 - (c) medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is more beneficial to the covered person than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

D. Helpful Terms

Life-threatening condition or disease means a condition or disease which, according to the current diagnosis by the physician or treating provider, has a high probability of causing the covered person's death within three years.

Serious medical condition means a health condition or illness that requires immediate medical attention, where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Seriously disabling means a health condition or illness that involves a serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

If you have any questions, contract the Department of Insurance by writing or calling:

Consumer Services Division
South Carolina Department of Insurance
Post Office Box 100105
Columbia, South Carolina 29202-3105
(803) 737-6180
(800) 768-3467

II. Obtaining Medical Records

A. Requesting Medical Records

You have the right to ask for a copy of medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under any State Regulations remain confidential.

III. Documentation

If you decide to request a review, you must give the person who will be responsible for processing the review any material justification or documentation for the review at the time the review is filed. You must also give that person the address and phone number where you can be contacted.

IV. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other person.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.