South Carolina Department of Insurance

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Bulletin Number 2011-04

To: All Licensed Insurers and Health Maintenance Organizations issuing health insurance coverage in the State of South Carolina, certified Independent Review Organizations and South Carolina certified Private Review Agents

From: David Black DB
Director

Subject: Compliance with the External Review Requirements of the Patient Protection and Affordable Care Act

Date: July 5, 2011

I. Purpose

The purpose of this Bulletin is to inform all licensed insurers and health maintenance organizations issuing health insurance coverage ("health insurance issuers"), certified Independent Review Organizations and Private Review Agents of the procedures for compliance with the external review requirements of the Patient Protection and Affordable Care Act (PPACA).

II. Overview

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Amendments to the PPACA were included in the Health Care and Education Reconciliation Act of 2010, which was enacted on March 30, 2010 (these two Acts are collectively referred to as the Affordable Care Act). Under the Affordable Care Act ("ACA"), health insurance issuers offering group or individual health insurance coverage must implement an effective external review process that meets certain standards. Section 2719 of the Public Health Service Act (PHSA) and related regulations set forth minimum requirements with regard to the external review of certain denied claims. State laws that do not meet the PHSA minimum requirements are preempted by the federal law.

The July 2010 Interim Final Rule (IFR) for external review set forth the 16 minimum consumer protection standards from the NAIC Uniform Model Act that a State external review process must include in order to be authorized under section 2719(b)(1) of the PHSA. Sub-regulatory guidance (Technical Release 2011-02) was issued on June 29, 2011 that includes temporary standards for State external review processes that are similar to the 16 mandatory consumer protections previously included in the IFR for external review. State external review programs that do not meet the federal minimum standards can continue to operate until 2014 if they meet the similar standards.

Certain provisions of the South Carolina Code do not currently meet the similar standards set forth in Technical Release 2011-02. Differences are set forth below in the External Review Guide and labeled as "New Standards." In order to allow time for health insurance issuers to make a reasonable transition to a different process, Technical Release 2011-02 provided for a transition period. The Department of Health and Human Services intends to issue determinations regarding State external review implementation no later than July 31, 2011.

The requirements for external review set forth in section 2719 of the PHSA and related regulations apply to all new or renewed health insurance coverage, unless the health insurance coverage is a grandfathered health plan as such term is defined in Section 1251 of the PHSA. Therefore, pursuant to 38-3-110(1), effective July 31, 2011, all health insurance issuers, certified Independent Review Organizations and Private Review Agents must adopt the new standards for all new or renewed health insurance coverage, unless the health insurance coverage is a grandfathered health plan, in order to comply with the temporary external review requirements of the Patient Protection and Affordable Care Act (PPACA) and to avoid preemption by the federal law. Grandfathered health plans may either comply with current South Carolina law or the new standards. Current South Carolina standards for external review remain in effect where they do not conflict with the provisions of PPACA.

III. External Review Guide

Effective Date: July 31, 2011

Issue	Current S.C. Law	New Standard
Threshold amount of claim	38-71-1950: Amount payable for covered benefits must be at least $500 to be eligible for external review.	No threshold.
Exhaustion of internal appeal process	38-71-1960: Requires that unless the covered person's physician certifies that the covered person has a serious medical condition or where	Covered persons may pursue an expedited external review while simultaneously pursuing an expedited internal appeal.

	the denial is based on a determination that the treatment is experimental or investigational, the health carrier's internal appeals process must first be exhausted.	The internal appeal process will be considered exhausted if the insurer fails to adhere to the requirements of 45 CFR 147.136(b)(2) with respect to the related claim or internal appeal or the issuer waives the internal appeal process.
Timeframe for filing a request for external review	38-71-1970: Within 60 days after receipt of a notice of adverse determination pursuant to 38-71-1940. 38-71-1980: For a request for an expedited external review, within 15 days of receipt of a notice of an adverse determination.	A request for external review must be made within four months of receiving notice than an adverse determination has been made under the insurer's internal appeal process. For a request for an expedited external review no time frame deadline.
Assignment of the Independent Review Organization	38-71-1970: Provides that the insurer will assign an independent review organization from a list of approved IROs maintained by the Department.	Insurers shall notify the Department of a request for external review and assignment of an IRO. The Department shall assign to the insurer an IRO for each case based upon a rotational system. The rotational system will be independent and impartial and in no event will the IRO be assigned by the issuer or the individual. An insurer shall verify that no conflict of interest exists with the assignment given by the Department. If a conflict does exist, the insurer shall contact the Department for an additional assignment.
Submission of additional information to the	38-71-1970: The covered person may submit	In the case of non-expedited reviews, the insurer shall

Independent Review Organization	additional information within seven days following receipt of the IRO's notice of assignment and of additional documents or information needed.	notify the covered person in writing of the assignment to an IRO and the right to submit additional information to be considered by the IRO within the first five business days of receipt of the letter. If an IRO receives information within the five day timeframe, the information shall be considered in the review and shall be forwarded to the insurer within one business day of receipt by the IRO.
Timeframes for decision	38-71-1980: Immediately upon making the decision relating to a request for an expedited external review.	For an expedited external review, the time shall not exceed 72 hours from receipt of the request. For a standard external review, the time period shall not exceed 45 days from receipt of the request.

The U.S. Departments of Treasury, Labor and Health and Human Services have issued model notices (available at www.dol.gov/ebsa/healthreform) that provide a template for the disclosures that should be made regarding external review (e.g., contact information and timeframes for initiating external review).

Insurers should submit requests for external review and assignment of an Independent Review Organization to:

James Byrd
Deputy Director
South Carolina Department of Insurance
Post Office Box 100105
Columbia, South Carolina 29202-3105

Phone: 803-737-6150
Fax: 803-737-6103
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All Independent Review Organizations must be accredited by a nationally recognized private accrediting organization.

IV. Questions:

Any questions about the contents of this Bulletin should be directed to:

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