

69-47. Private Review Agents.

(Statutory Authority: 1976 Code Section Section 38-70-60, 1-23-10 et seq., and Acts 311 of 1990)

I. Purpose.

The purpose of this regulation is to implement and enforce the provisions and statutory requirements contained in Act 311 of 1990 and to establish applicable fees and standards for private review agents operating in South Carolina.

II. Definitions.

For the purposes of this regulation, the following terms are defined as:

A. “Appeal”—A request to reconsider a determination not to certify an admission, procedure, extension of stay or other health care service.

B. “Certificate”—Renewable certificate of registration granted by the Commissioner to a private review agent, authorizing the private review agent to perform utilization reviews in this State for two years. This certificate is not transferable.

C. “Certification”—A determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care or effectiveness under the applicable health benefit plan.

D. “Commissioner”—The Chief Insurance Commissioner of South Carolina.

E. “Discharge Planning”—The process of assessing a patient’s need for treatment after hospitalization to facilitate the necessary services and resources for an appropriate and timely discharge.

F. “Health Care Provider”—Any attending health care provider, facility or practitioner, authorized under state or federal law to bill for health care services rendered.

G. “Other Party Designated”—Any person or entity designated by the insured to receive notice of certification or denials thereof. This term shall presumptively include the primary attending health care provider and any other affected health care provider of record.

H. “Private Review Agent”—A corporation, partnership, association or any other entity performing utilization reviews. All private review agents not hereinafter exempt must obtain a certificate.

1. The State of South Carolina or any South Carolina business entity which uses its employees to perform utilization reviews on behalf of its employees or any hospital which performs utilization reviews is not required to obtain a certificate, unless the hospital is performing those reviews for a fee for an entity which is not owned or affiliated with the hospital.

2. Insurance companies, administrators of insurance benefit plans and health maintenance organizations licensed and regulated by the Department which perform utilization reviews are not required

to obtain a certificate. However, each of these entities must comply with Sections IV through XI of this regulation.

3. Private review agents performing utilization reviews only for single-employer, self-insured employee health benefit plans are not required to obtain a certificate.

4. Private review agents performing utilization reviews only for health care services provided pursuant to a federal law, which specifically preempts state regulation, are not required to obtain a certificate.

I. “Utilization Criteria”—The written policies, rules, medical protocols, or guides used by the private review agent to review, grant or deny certification.

J. “Utilization Review”—A system for reviewing the necessary, appropriate, and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients.

III. Certificate of Registration/Application Fee/Annual Registration Fee.

A. Before performing utilization reviews on residents of this State, all private review agents not exempted by Section II.G. of this regulation must obtain a certificate using the application provided by the Commissioner. The application fee is \$400.00. Any significant change in utilization review criteria, program design, or service delivery must be updated annually by not later than July 1. Every private review agent must pay a biennial certificate fee of \$800.00 by not later than July 1. If the private review agent’s certificate lapses for nonpayment of the biennial certificate fee or if the certificate is terminated for any reason, then the private review agent must refile the application along with the \$400.00 application fee. Certificates will be renewed by the Commissioner biennially on July 1 of even-numbered years.

B. The source of each private review agent’s utilization criteria must be reflected on the application for a certificate. Utilization criteria must be periodically reviewed and revised as appropriate. Any significant change in the source of a private review agent’s utilization criteria must be disclosed annually by no later than July 1.

IV. Procedures for Utilization Review Determinations.

A. Private review agents must have written procedures to assure that utilization reviews are conducted in a timely manner.

1. Private review agents must make a certification determination within two working days of receipt of the necessary information. Private review agents must make a certification determination of an extended stay or additional service within one working day of receipt of the additional information. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review. Regardless, a certification determination must be made within thirty days of receipt of the request.

2. Private review agents may review ongoing inpatient stays, but must not routinely conduct daily review on all such stays. The frequency of such reviews should vary based on the severity or complexity of the patient’s condition or on the necessary treatment and discharge planning activity.

3. Private review agents must establish a reasonable target review period for each admission. Except for contractually required case management activities related to discharge planning programs, private review agents may not contact a hospitalized patient until the final day of the target period.

B. Private review agents must have in place written procedures for providing notification of their determinations in accordance with the following:

1. When a determination is made to issue a certification, notification must be provided immediately either by telephone or by telecopier facsimile transmission machine to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated. Notification of the certification must thereafter be transmitted in writing to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated within two working days of the determination or request. The certification must include the certified length of stay and the date of the next review. A written confirmation of certification of an extended stay or additional service must include the number of extended days, the next review date, the new total number of days approved and the date of admission. All notifications of certification must include the following or similar language: "This certification does not guarantee payment of benefits under your insurance policy. That determination can only be made by your insurer under the terms of your insurance policy."

2. When a determination is made to deny certification, notification must be provided immediately either by telephone or by telecopier facsimile transmission machine to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated. Notification of the denial of certification must be transmitted in writing to the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated within one working day of the determination or request. The written notification must include the principal reason(s) for the denial of certification and the procedure for appealing the denial of certification.

V. Appeals Process.

A. Private review agents must have procedures for appeals of denials of certification. The right to appeal must be available to the the person or entity who initiated the request, or to the patient, enrollee, insured or other party designated. The right to appeal must include the right to request that the health care provider performing the review must practice the same profession as the attending health care provider and the right to request that the review be performed by a health care provider who did not make the initial denial of certification. The appeal procedure may require that an appeal be filed within a specified period from the denial of certification. In no event may this period be less than sixty days from the denial of certification.

1. Standard Appeal.

a. Private review agents must establish procedures for appeals to be made both in writing and by telephone.

b. Private review agents must notify in writing the person or entity who initiated the request, or the patient, enrollee, insured or other party designated of its determination on an appeal, as soon as practical, but in no case later than thirty days after receiving all information necessary to complete the appeal. If the appeal is denied, the notification must contain justification for the denial. In extraordinary circumstances, the thirty-day period to determine appeals may be extended for not more than sixty days. Private review agents must maintain records documenting the necessity for extending standard appeal determinations, which must be made available to the Commissioner on demand.

2. Expedited Appeal.

When a determination to deny certification is made and the person or entity who initiated the request, or the patient, enrollee, insured or or other party designated believes that the determination warrants immediate appeal, an opportunity to appeal that determination over the telephone on an expedited basis must be afforded. A decision on an expedited appeal must be communicated to the appellant by telephone within two working days of receipt of all information necessary to complete the appeal. Private review agents must have written procedures to assure reasonable access to their consulting health care providers for such appeals. Expedited appeals which do not resolve a difference of opinion may, at the option of the appellant, be resubmitted through the standard appeal process.

VI. Information Upon Which Utilization Review Is Conducted.

A. When conducting utilization reviews, private review agents must collect only the information necessary to issue a certification.

B. Private review agents must not require health care providers to supply numerically codified diagnoses or procedures as a condition for certification. Private review agents may request such coding, since its inclusion may expedite utilization reviews.

C. Private review agents must not require copies of medical records on all utilization reviews as a matter of routine. Copies of pertinent medical records may be required when a difficulty develops in certification or for retrospective review.

VII. Retrospective Review.

Private review agents may conduct retrospective reviews of certifications only for purposes of internal quality assurance, procedural compliance with the terms of the health benefit plan and auditing of the appropriateness of health care services certified and provided. Once certification is issued by a private review agent, then except for fraud committed by patient, enrollee, insured, or health care provider, retrospective review of that certification must not result in any additional cost to an innocent patient, enrollee, insured, or health care provider. Except as provided above, any errors in certification must be resolved between the private review agent and the third-party payer.

VIII. Accessibility.

A. Private review agents must conduct utilization reviews and provide access to their utilization review staff by a toll-free line at a minimum of forty hours per week, during normal business hours, in the health care provider's local time zone, unless otherwise mutually agreed.

B. Private review agents must provide sufficient telephone lines to ensure a reasonable response time to inquiries. A reasonable response time is a telephonic queue time not exceeding ninety seconds.

C. Private review agents conducting on-site utilization reviews must verify their identity to the health care provider and comply with health care provider protocols and administrative procedures to minimize disruption of patient care or operations of the health care provider.

D. Private review agents not exempted by Section II.G. must provide their South Carolina certificate number upon request.

IX. Staff and Program Qualifications.

A. Staff Qualifications.

1. Private review agents must have adequate utilization review staff who are properly trained, qualified, and supervised by appropriate health care providers, and supported by utilization criteria.

2. Health care providers conducting utilization reviews must be licensed as health care providers by an approved state licensing agency in the United States.

B. Program Qualifications.

1. Utilization criteria must be established under the direct supervision of a health care provider licensed in the same profession and practicing in the same or a similar specialty as typically manages the medical condition, procedure or treatment. A summary description of the utilization criteria must be provided to the Commissioner on demand.

2. Private review agents must develop and use an internal ongoing written quality assessment program. This written program must be made available to the Commissioner on demand.

3. Private review agents must maintain materials informing insureds or enrollees of the requirements for certification. Those materials must include an overview of the rights and responsibilities of insureds and enrollees, the telephone number and address of the private review agent and a description of the appeals process. The private review agent must either directly distribute these materials to the insured or enrollee or provide them to the insurer or payer for distribution.

X. Confidentiality.

A. Private review agents must have written procedures for assuring that patient-specific information obtained during utilization reviews will be:

1. Kept confidential in accordance with applicable federal and state laws; and

2. Used solely for the purposes of utilization reviews, internal quality assurance, discharge planning, case management or claims payment.

B. Patient-specific information must be disclosed to the Commissioner on demand, subject to an appropriate proprietary agreement to ensure confidentiality.

C. Statistical data which does not provide sufficient information to allow identification of individual patients is not considered confidential for purposes of this regulation.

XI. Effective Date.

This regulation shall become effective ninety days after final publication in the State Register.

HISTORY: Added by State Register Volume 19, Issue No. 5, eff May 26, 1995.