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CHAPTER 59

Claims Practices

ARTICLE 1

In General

**SECTION 38‑59‑10.** Proof of loss forms required to be furnished.

 When an insurer under an insurance policy requires a written proof of loss after the notice of the loss has been given by the insured or beneficiary, the insurer or its representative shall furnish a blank to be used for that purpose. If the forms are not furnished within twenty days after the receipt of the notice, the claimant is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, character, and extent of the loss for which claim is made. The twenty‑day period after notice of loss to furnish forms applies to all types of insurance unless a lesser time period is specifically provided by law.

HISTORY: Former 1976 Code Section 38‑59‑10 [1976 Act No. 673; 1976 Act No. 745 Section 1] recodified as Section 38‑79‑10 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑9‑300 [1947 (45) 322; 1952 Code Section 37‑166; 1962 Code Section 37‑166] recodified as Section 38‑59‑10 by 1987 Act No. 155, Section 1.

**SECTION 38‑59‑20.** Improper claim practices.

 Any of the following acts by an insurer doing accident and health insurance, property insurance, casualty insurance, surety insurance, marine insurance, or title insurance business, if committed without just cause and performed with such frequency as to indicate a general business practice, constitutes improper claim practices:

 (1) Knowingly misrepresenting to insureds or third‑party claimants pertinent facts or policy provisions relating to coverages at issue or providing deceptive or misleading information with respect to coverages.

 (2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, including third‑party claims arising under liability insurance policies.

 (3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims, including third‑party liability claims, arising under its policies.

 (4) Not attempting in good faith to effect prompt, fair, and equitable settlement of claims, including third‑party liability claims, submitted to it in which liability has become reasonably clear.

 (5) Compelling policyholders or claimants, including third‑party claimants under liability policies, to institute suits to recover amounts reasonably due or payable with respect to claims arising under its policies by offering substantially less than the amounts ultimately recovered through suits brought by the claimants or through settlements with their attorneys employed as the result of the inability of the claimants to effect reasonable settlements with the insurers.

 (6) Offering to settle claims, including third‑party liability claims, for an amount less than the amount otherwise reasonably due or payable based upon the possibility or probability that the policyholder or claimant would be required to incur attorneys’ fees to recover the amount reasonably due or payable.

 (7) Invoking or threatening to invoke policy defenses or to rescind the policy as of its inception, not in good faith and with a reasonable expectation of prevailing with respect to the policy defense or attempted rescission, but for the primary purpose of discouraging or reducing a claim, including a third‑party liability claim.

 (8) Any other practice which constitutes an unreasonable delay in paying or an unreasonable failure to pay or settle in full claims, including third‑party liability claims, arising under coverages provided by its policies.

HISTORY: Former 1976 Code Section 38‑37‑1110 [1962 Code Section 37‑591.56; 1974 (58) 2718] recodified as Section 38‑59‑20 by 1987 Act No. 155, Section 1.

**SECTION 38‑59‑25.** Coverage decisions not constituting practice of medicine.

 A determination of medical necessity of a decision affecting the diagnosis and/or treatment of a patient is not the practice of medicine, provided:

 (A) it is a coverage decision denying health care services by an insurer that is based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract; or

 (B) it is a coverage decision approving a covered benefit for health care services that provides for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; or

 (C) it is a coverage decision denying coverage for a covered benefit for a health care service that provides diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease excluding, except where otherwise provided for by law, experimental, investigational, or cosmetic purposes, if the denial is issued by a licensed physician who has not wilfully and knowingly, or with reckless disregard or gross negligence, or with the intent solely to delay payment of the claim in bad faith, ignored nationally recognized protocols or standards of medical care in rendering such a decision. A good faith request for records or additional information is not a delay for purposes of this section. A person providing medical necessity review services for a health insurer or health maintenance organization who is subject to an inquiry regarding whether the person has been practicing medicine pursuant to this section has the right to remove the case to the Administrative Law Court upon petition of the person. If the Administrative Law Court determines that a complaint is filed, pursuant to this section, to harass or intimidate a person or is otherwise not based on a good faith belief that the provisions of this section are being violated, the defendant is entitled to an award of attorney’s fees and the costs of defending the case.

HISTORY: 2008 Act No. 411, Section 7, eff June 25, 2008.

**SECTION 38‑59‑30.** Notice and hearing by director or designee; penalties.

 If, after due notice and hearing, the director or his designee determines that the insurer has engaged in any of the improper claim practices defined in Section 38‑59‑20, he shall order the insurer to cease and desist from the practice and may impose a penalty as provided in Section 38‑2‑10. If the penalty is imposed, the penalty may not be considered a cost of the insurer for purposes of determining whether or not the rates of the insurer warrant adjustment.

HISTORY: Former 1976 Code Section 38‑37‑1120 [1962 Code Section 37‑591.57; 1974 (58) 2718] recodified as Section 38‑59‑30 by 1987 Act No. 155, Section 1; 1988 Act No. 374, Section 30; 1993 Act No. 181, Section 723.

**SECTION 38‑59‑40.** Liability for attorneys’ fees where insurer has refused to pay claim.

 (1) In the event of a claim, loss, or damage which is covered by a policy of insurance or a contract of a nonprofit hospital service plan or a medical service corporation and the refusal of the insurer, plan, or corporation to pay the claim within ninety days after a demand has been made by the holder of the policy or contract and a finding on suit of the contract made by the trial judge that the refusal was without reasonable cause or in bad faith, the insurer, plan, or corporation is liable to pay the holder, in addition to any sum or any amount otherwise recoverable, all reasonable attorneys’ fees for the prosecution of the case against the insurer, plan, or corporation. The amount of reasonable attorneys’ fees must be determined by the trial judge and the amount added to the judgment. The amount of the attorneys’ fees may not exceed one‑third of the amount of the judgment.

 (2) If attorneys’ fees are allowed and, on appeal by the defendant, the judgment is affirmed, the Supreme Court or the court of appeals shall allow to the respondent an additional sum as the court adjudges reasonable as attorneys’ fees of the respondent on the appeal.

 (3) Nothing in this section may be construed to alter or affect the Tyger River Pine Co. v. Maryland Casualty Co., 161 SE 491, 163 SC 229, doctrine.

 (4) This section applies to cases filed or removed to federal court and cases appealed in the federal court system.

HISTORY: Former 1976 Code Section 38‑9‑320 [1962 Code Section 37‑167.1; 1972 (57) 2203] recodified as Section 38‑59‑40 by 1987 Act No. 155, Section 1; 1989 Act No. 148, Section 50; 1999 Act No. 55, Section 38.

**SECTION 38‑59‑50.** Payment or settlement of benefits in merchandise or services prohibited.

 It is unlawful for an insurer to make payment or settlement of benefits arising under life, endowment, accident, health, or hospitalization policies written by the insurer in merchandise, services rendered or agreed to be rendered, or to issue a policy which provides for settlement in merchandise or services rendered or to be rendered.

 An insurer violating this section pays a penalty of ten times the amount of the policy, certificate, or other evidence of insurance to be collected in a suit by the policyholder or his legal representatives or beneficiary. An officer, agent, or servant of an insurer who violates this section is guilty of a misdemeanor and, upon conviction, must be fined in the discretion of the court or imprisoned not more than three years, or both.

HISTORY: Former 1976 Code Section 38‑9‑330 [1947 (45) 322; 1952 Code Section 37‑168; 1958 (50) 1554; 1962 Code Section 37‑168] recodified as Section 38‑59‑50 by 1987 Act No. 155, Section 1; 1988 Act No. 374, Section 31; 1993 Act No. 184, Section 220.

ARTICLE 2

South Carolina Health Care Financial Recovery and Protection Act

**SECTION 38‑59‑200.** Citation of article.

 This article may be cited as the “South Carolina Health Care Financial Recovery and Protection Act”.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑210.** Definitions.

 As used in this article:

 (1) “Insurer” means an insurance company, a health maintenance organization, and any other entity providing health insurance coverage, as defined in Section 38‑71‑670(6), which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

 (2) “Health care services” means services included in furnishing an individual medical care or hospitalization, or services incident to the furnishing of medical care or hospitalization, and other services to prevent, alleviate, cure, or heal human illness, injury, or physical disability.

 (3) “Health maintenance organization” means an organization as defined in Section 38‑33‑20(8).

 (4) “Health insurance plan” means a health insurance policy or health benefit plan offered by a health insurer or a health maintenance organization that provides health insurance coverage, as defined in Section 38‑71‑670(6).

 (5) “Physician” means a doctor of medicine or doctor of osteopathic medicine licensed by the South Carolina Board of Medical Examiners.

 (6) “Provider” means a physician, hospital, or other person properly licensed, certified, or permitted, where required, to furnish health care services.

 (7) “Participating provider” means a provider who provides covered health care services to an insured or a member pursuant to a contract with an insurer or health insurance plan.

 (8) “Clean claim” means an eligible electronic or paper claim for reimbursement that:

 (a) is received by the insurer within one hundred twenty business days of the date the health care services at issue were performed;

 (b)(i) when submitted via paper has all the elements of the standardized CMS 1500 or UB 04 claim form, or the successor of each as either may be amended from time to time; or

 (ii) when submitted via an electronic transaction, uses only permitted standard code sets and has all the elements of the standard electronic formats as required by the Health Insurance Portability and Accountability Act of 1996 and other federal and state regulatory authority;

 (c) is for health care services covered by the health insurance plan and rendered to an insured person by a provider eligible for reimbursement under the health insurance plan;

 (d) has any corresponding referral that may be required for the applicable claim;

 (e) is a claim for which the insurer is the primary payor, or for which the insurer’s responsibility as a secondary payor has been clearly established;

 (f) has no material defect, error, or impropriety that would affect the adjudication of the claim;

 (g) includes all required substantiating documentation or coding;

 (h) is not subject to any particular circumstance that the insurer reasonably believes, subject to review by the Department of Insurance, would prevent accurate or timely payment from being made on the claim under the terms of the health insurance plan, the participating provider agreement, or the insurer’s published filing requirements; and

 (i) is under a health insurance plan for which the insurer has been timely paid all applicable premiums.

 (9) “Force majeure” means any act of God, governmental act, act of terrorism, war, fire, flood, earthquake, hurricane, or other natural disaster, explosion or civil commotion.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑220.** Requesting fee schedule from insurer; confidentiality.

 (A) Within six months of the effective date of this article, each insurer, upon written request from a physician who is also a participating provider will provide, by CD‑ROM, or electronically at the insurer’s option, the fee schedule that is contracted with that physician for up to 100 CPT(r) Codes customarily and routinely used by the specialty type of such physician. Each physician may request from an insurer an updated fee schedule no more than two times annually.

 (B) A physician requesting a fee schedule pursuant to subsection (A) may elect to receive a hard copy of the fee schedule in lieu of the foregoing; however, the insurer may charge the physician a reasonable fee to cover the increased administrative costs of providing the hard copy.

 (C) The physician shall keep all fee schedule information provided pursuant to this section confidential. The physician shall disclose fee schedule information only to those employees of the physician who have a reasonable need to access this information in order to perform their duties for the physician and who have been placed under an obligation to keep this information confidential. Any failure of a physician’s office to abide by this subsection shall result in the physician’s forfeiture of the right to receive fee schedules pursuant to this section and at the option of the insurer may constitute a breach of contract by the physician.

 (D) Nothing in this section prohibits an insurer from basing actual compensation to the physician on the insurer’s maximum allowable amount or other contract adjustments, including those stated in the patient’s plan of benefits, or both.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑230.** Time frame for payment of clean claims; acknowledging receipt of claim; processing of electronic claims by billing service.

 (A) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted via paper within forty business days following the later of the insurer’s receipt of the claim or the date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer:

 (1) to determine that such claim does not contain any material defect, error, or impropriety; or

 (2) to make a payment determination.

 (B) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted electronically within twenty business days following the later of the insurer’s receipt of the claim or the date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer:

 (1) to determine that such claim does not contain any material defect, error, or impropriety; or

 (2) to make a payment determination.

 (C) An insurer shall affix to or on paper claims, or otherwise maintain a system for determining, the date claims are received by the insurer. An insurer shall send an electronic acknowledgement of claims submitted electronically either to the provider or the provider’s designated vendor for the exchange of electronic health care transactions. The acknowledgement must identify the date claims are received by the insurer. If an insurer determines that there is any defect, error, or impropriety in a claim that prevents the claim from entering the insurer’s adjudication system, the insurer shall provide notice of the defect or error either to the provider or the provider’s designated vendor for the exchange of electronic health care transactions within twenty business days of the submission of the claim if it was submitted electronically or within forty business days of the claim if it was submitted via paper. Nothing contained in this section is intended or may be construed to alter an insurer’s ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

 (D) A clearinghouse, billing service, or any other vendor that contracts with a provider to deliver health care claims to an insurer on the provider’s behalf is prohibited from converting electronic claims received from the provider into paper claims for submission to the insurer. A violation of this subsection constitutes an unfair trade practice under Chapter 5, Title 39, and individual providers and insurers injured by violations of this subsection have an action for damages as set forth in Section 39‑5‑140.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑240.** Interest on payments later than applicable period; exceptions.

 (A) For each clean claim with respect to which an insurer has directed the issuance of a check or the electronic funds transfer later than the applicable period specified in Section 38‑59‑230, the insurer shall pay interest in the same manner and at the same rate set forth in Section 34‑31‑20(A) on the balance due on each claim computed from the twenty‑first or the forty‑first business day, as appropriate, based on the circumstances described in Section 38‑59‑230, up to the date on which the insurer directs the issuance of the check or the electronic funds transfer for payment of the clean claim. At the insurer’s election, interest paid pursuant to this section must be included in the claim payment check or wire transfer or must be remitted periodically, but at least quarterly, in a separate check or wire transfer along with a report detailing the claims for which interest is being paid.

 (B) No insurer has an obligation to make any interest payment pursuant to subsection (A):

 (1) with respect to any clean claim if within twenty business days of the submission of an original claim submitted electronically or within forty business days of an original claim submitted via paper, a duplicate claim is submitted while the adjudication of the original claim is still in process;

 (2) to any participating provider who balance bills a plan member in violation of the participating provider’s agreement with the insurer;

 (3) with respect to any time period during which a force majeure prevents the adjudication of claims; or

 (4) when payment is made to a plan member.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑250.** Initiation of overpayment recovery efforts.

 (A)(1) An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least thirty business days prior to engaging in the overpayment recovery efforts, other than for recovery of duplicate payments or other similar adjustments relating to:

 (a) claims where a provider has received payment for the same services from another payor whose obligation is primary; or

 (b) timing or sequence of claims for the same insured that are received by the insurer out of chronological order in which the services were performed.

 (2) The written notice required by this section shall include:

 (a) the patient’s name;

 (b) the service date;

 (c) the payment amount received by the provider;

 (d) a reasonably specific explanation of the change in payment; and

 (e) if the claim is submitted pursuant to a provider contract that includes an appeals process, the telephone number or a mailing address through which the provider may initiate an appeal, and the deadline by which an appeal must be received.

 (B) An insurer may not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by the provider; however, this time limit does not apply to the initiation of overpayment recovery efforts:

 (1) based upon a reasonable belief of fraud or other intentional misconduct;

 (2) required by a self‑insured plan; or

 (3) required by a state or federal government program.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008); 2012 Act No. 243, Section 1, eff September 16, 2012.

**SECTION 38‑59‑260.** Application of requirements of article.

 The requirements of this article do not apply to claims that are processed under any national account delivery program in which an insurer participates but is not solely responsible for the processing and payment of the claims, or claims for services under a program offered or sponsored by any state or federal governmental entity other than in its capacity as an employer, or both.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑270.** Enforcement; cease and desist orders; penalty; private right of action.

 The Department of Insurance shall enforce the provisions of this article. If, after due notice and hearing, the Director of the Department of Insurance or his designee determines that an insurer has failed to meet the obligations imposed by this article, he shall order the insurer to cease and desist from the practice, to correct any errant business practices, and to make any payments due, including applicable interest. If an insurer does not comply with the order within thirty days, the director or his designee may then impose a penalty as provided in Section 38‑2‑10. Nothing in this article may be construed to create a private right of action to enforce the specific provisions of this article.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).