South Carolina Statutes and Regulations

	Statute/Regulation	Description	Comments
Prompt Payment of Claims	*Deadline* S.C. Code Ann. § 38-59-230(A)-(B)	An insurer must pay a clean claim received via paper within 40 business days and clean electronic claims within 20 business days following the later of (1) the date the claim is received; or (2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a clean claim.	
	Penalty S.C. Code Ann. § 38-59-240	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, 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. 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. An insurer does not have an obligation to make any interest payment: (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.	Section 34-31-20(A) sets the legal interest at the rate of **8.75%** per annum.

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	Statute/Regulation	Description	Comments
	"Clean Claim" Definition S.C. Code § 38-59-210	"Clean claim" means an eligible electronic or paper claim for reimbursement that: (a) is received by the insurer within 120 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.	

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	Statute/Regulation	Description	Comments
	Additional Information & Acknowledgement of Receipt S.C. Code Ann. § 38-59-230(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.	

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	Statute/Regulation	Description	Comments
	Refunds / Overpayment Recovery Efforts S.C. Code § 38-59-250	An insurer may not initiate overpayment recovery efforts more than 18 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. An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least 30 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.	
Prompt Payment of Workers' Compensation Claims	S.C. Code Ann. § 42-9-360(D)	Deadline: Insurers must pay a claim no later than 30 days from the date the authorized health care provider tenders request for payment to the employer's representative, unless the commission has received a request to review the medical bill. Penalty: N/A	

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	Statute/Regulation	Description	Comments
Pre-existing Conditions	*Group Health Plans* S.C. Code Ann. § 38-71-850	*Standard HIPAA Guidelines:* Pre-existing waiting period can be no longer than 12 months (or 18 months for late enrollees); the look-back period cannot exceed 6 months. Pre-existing condition is a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six month period ending on the enrollment date. Pregnancy cannot be considered a pre-existing condition. For creditable coverage to apply there must not be a break in coverage of more than 63 days.	While the referenced citations are still valid statutes/regs in SC, as of 1/1/14 the federal Affordable Care Act precludes pre-existing condition exclusions (except for grandfathered plans).

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	Statute/Regulation	Description	Comments
Pre-existing Conditions (cont'd.)	*Individual Health Plans (Non-HMO)* S.C. Code of Regulations R. 69-34 (F)(10), E(6)	Pre-existing waiting period can be no longer than 12 months (when the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment). If the insurer uses an application form designed to elicit the complete health history of a prospective insured, the following definition of pre-existing condition applies: 1. A condition misrepresented or not revealed in the application and for which symptoms existed prior to the effective date of coverage that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by or received from a physician. If the insurer uses a simplified application or elects not to use an application, the following definition of pre-existing condition applies: 2. A condition for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 1 year period preceding the effective date of the coverage or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 5 year period preceding the effective date of the coverage.	

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	Statute/Regulation	Description	Comments
Pre-existing Conditions (cont'd.)	*HMOs* S.C. Code Regs. 69-22, Section IV	A health maintenance organization contract may contain a provision limiting coverage for preexisting conditions. The preexisting conditions must be covered no later than twelve months without medical care, treatment, or supplies ending after the effective date of the coverage or twelve months after the effective date of the coverage, whichever occurs first. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended no more than twelve months prior to the effective date of a person's coverage".	

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	Statute/Regulation	Description	Comments
Emergency Services	S.C. Code Ann. § 38-71-1520	"Emergency medical care" means those health care services provided in a hospital emergency facility to evaluate and treat an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.	
	S.C. Code Ann. § 38-71-1530 (B),(D), (E)	Appropriate intervention must be initiated by medical personnel to stabilize any emergency medical condition before requesting authorization for the treatment by a managed care organization. A managed care organization shall provide coverage and shall subsequently pay providers for emergency medical care services provided to an insured who presents an emergency medical condition. A managed care organization may not retrospectively deny or reduce payments to providers for emergency medical care of an insured even if it is determined that the emergency medical condition initially presented is later identified through screening not to be an actual emergency, except in these cases: 1. material misrepresentation, fraud, omission, or clerical error; 2. a payment reduction due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured; 3. cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.	

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	Statute/Regulation	Description	Comments
Coordination of Benefits	S.C. Code Regs 69-43, (III)(B)	The benefits of the primary plan must be determined before those of the secondary plan and without considering the other plan's benefits.	
	S.C. Code of Regs 69-43(V)(A)	If a person has coverage as a dependent and as a non-dependent, the plan covering them as an employee, member, or subscriber is primary. **The "Birthday Rule" -- Dependent Child/Parents Not Separated or Divorced** ♦ Applies where child is covered under both the mother and the father's policy as a dependent, and the parents are not separated or divorced. ♦ The benefits of the plan of the parent whose birthday falls earlier in a year is determined before those of the plan of the parent whose birthday falls later. If they have the same birthday, the plan of the parent who has been enrolled in their respective plan longest is primary.	
	S.C. Code of Regs 69-43(V)(B)	**Dependent Child/Separated or Divorced Parents** Where parents are divorced or separated, benefits are determined in the following order: (1) Custodial Parent (2) Spouse of Custodial Parent (3) Noncustodial Parent If a court order dictates one or the other parent is responsible for obtaining and maintaining coverage, that plan is primary.	
	S.C. Code of Regs 69-43(V)(C)(5)	**Joint Custody** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination according to the "Birthday Rule"	

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	Statute/Regulation	Description	Comments
Parental & Spousal Liability	S.C. Code Ann. § 20-5-60	A husband shall not be liable for the debts of his wife contracted prior to or after their marriage, *except for her necessary support and that of their minor children residing with her*.* An individual is liable for the necessary medical care of his or her spouse, and parents are responsible for cost of medical care provided by a hospital to their minor child, even if the individual is not contractually liable for necessaries. *Trident Regional Medical Center v. Evans*, 317 S.C. 346, 454 S.E.2d 343 (S.C. Ct. App. 1995).	* The necessaries doctrine, as codified in § 20-5-60, denied husbands equal protection of the laws by failing to impose a reciprocal obligation on wives; however, in light of legislative and common law developments, it was determined that the doctrine of necessaries allowed third parties providing necessaries to a husband or wife to bring an action against the individual's spouse, resolving the equal protection issue. *Richland Memorial Hosp. v. Burton* (S.C. 1984) 282 S.C. 159, 318 S.E.2d 12.
Hospital Liens		South Carolina statutes do not provide for hospital liens against third-party liability recoveries.	