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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the web site at <http://www.sos.state.mo.us/adrules/pubsched.asp>

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RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 26, *Missouri Register*, page 27. The approved short form of citation is 26 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation, i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—Cite material in the RSMo by date of legislative action. The note in parentheses gives the original and amended legislative history. The Office of the Revisor of Statutes recognizes that this practice gives users a concise legislative history.

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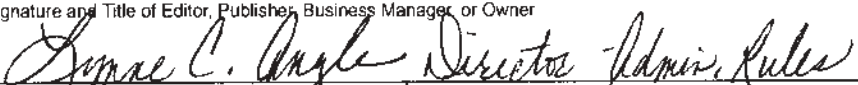
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- In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
- Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

FROM THIS ANGLE . . .

Tip on Timelines

Many agencies continue to have some problems keeping track of their timelines as to when they should/should not file certain documents in the various phases of rulemaking. If you are having difficulty in “counting” your days, please refer to the “Calendars and Timelines” tab in your rulemaking manual. This will assist you in counting calendar and/or legislative days; or, alternatively, contact us and we will be happy to assist.

Another useful tip that many agencies are now utilizing is once you have determined your critical dates in the rulemaking process; place those dates on your calendar as an “appointment” in Outlook. Your computer system will “flag” you that you must file your next step of the paperwork involved in the rulemaking process.

We hope this useful tip will help you in filing your paperwork on the appropriate date and avoid missing a date and, therefore, needing to begin again.

Rulemaking 1-2-3, Missouri Style Classes

Having difficulty with the rulemaking process? Do you have a new employee who is now responsible for filing rulemakings for your agency? Are you aware you can schedule a rulemaking class with our office for your agency? We will offer a training here at our office, we will come to your agency, we will offer one-on-one classes or design a class for your agency with specific questions for one or 100 people.

Please contact us if we may assist you in any way with the rulemaking process.



Lynne C. Angle
Director, Administrative Rules

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or (thirty) 30 legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 20—DEPARTMENT OF INSURANCE
Division 500—Property and Casualty
Chapter 6—Workers' Compensation and Employer's Liability

EMERGENCY AMENDMENT

20 CSR 500-6.700 [*Premium Discounts for Using Managed Care Programs*] *Workers' Compensation Managed Care Organizations*. The department is amending the title of the rule, deleting sections (1), (2), and (5) through (8), modifying and renumbering sections (3) and (4), deleting two exhibits, and adding seven new sections and one new exhibit.

PURPOSE: *The emergency amendment updates this rule to implement section 287.135, RSMo.*

EMERGENCY STATEMENT: *This amendment is an "emergency" version of a proposed amendment for which an order of rulemaking has also been submitted to the secretary of state. The final provisions of the two (2) versions are identical. They are designed to implement the provisions section 287.135, RSMo, which was enacted in 1993 as part of workers' compensation reforms contained in Senate Bill 251. Section 287.135, RSMo calls for the Department of Insurance to promulgate rules on a number of topics relating to workers' compensation managed care organizations (MCOs), including rules setting forth the criteria under which the fees charged by an MCO shall be reimbursed by an employer's insurer. The department has formally*

*attempted to promulgate such rules on three (3) previous occasions. The department's most recent previous attempt was disapproved by the General Assembly's Joint Committee on Administrative Rules (JCAR) at a hearing on March 7, 2002. During that hearing, JCAR clarified the legislative intent behind section 287.135, RSMo, and directed the department to submit new language to implement that section. Subsequently, during the regular legislative session of 2002, the General Assembly passed and the governor thereafter signed Senate Concurrent Resolution 58, which specifically directed the department "...to promulgate an emergency rule and a proposed rule with a sunset of December 31, 2002, which would provide a mechanism to pay managed care organizations, including those whose claims have been denied since the passage of Senate Bill No. 251 in 1993, based on the absence of a rule as required pursuant to Section 287.135, RSMo..." This emergency amendment is designed to carry out the directive of SCR 58 that an emergency rule be promulgated. This emergency amendment is necessary to preserve the compelling governmental interest of having an executive branch agency fulfill a mandate contained in legislation, duly enacted by the General Assembly and signed by the governor, calling for such an emergency rule. If an emergency version of this amendment is not implemented, the department's attempt to comply with this directive will be thwarted, blocking the department in the performance of its constitutional duty as an executive branch agency to faithfully execute the laws of this state. In addition, the sunset date of December 31, 2002 contained in SCR 58 demonstrates the General Assembly's intent that the issues surrounding this rule be wrapped up as soon as possible, and an emergency effective date for a rule on these issues is necessary to effectuate that intent. Since a hearing has already been held on the companion proposed amendment, since the department has responded to the various comments made regarding that proposal in an order of rulemaking to be published in the *Missouri Register*, and since the order of rulemaking has been in the possession of JCAR for a period of thirty (30) days, the department believes it has followed procedures best calculated to assure fairness to all interested persons and parties under the circumstances. The scope of this emergency amendment is limited to the conditions creating the emergency and complies with the protections extended in the *Missouri* and *United States Constitutions*. This emergency amendment was filed on September 16, 2002 and will become effective September 26, 2002, expires December 31, 2002.*

[(1) Upon issuance or renewal of a Workers' Compensation insurance policy, there shall be a reduction in the total premium charged to an employer for the policy for the first three (3) years during which the employer contracts with a managed health care system which has met the certification requirements of this rule and which serves the geographic area in which the employer is located. The premium reduction shall be five percent (5%) of the total premium which would otherwise be charged to the employer for each of the three (3) initial policy years under the certified managed care system. An insurer may require the employer to notify it of the employer's intent to contract with certified managed care system and to execute any such contract, prior to the issue date or renewal date of the policy, before granting the reduction. This arrangement shall be evidenced by the following documents:

(A) An endorsement to the Workers' Compensation policy setting forth the use of the certified managed care system and the extension of the five percent (5%) reduction in premium. The endorsement may include provisions on the effect of the employer's use of providers outside the terms of the managed care agreement;

(B) A contract between the certified managed care system and the employer specifying the terms and conditions

associated with the use of the managed care system, including the employer's agreement that the use of the organization is the free exercise of the employer's right to choose a health care provider under section 287.140, RSMo;

(C) A certification of a managed care utilization form to be given to the employer's insurer documenting the existence of the contract specified in subsection (1)(B), as set forth in Exhibit II of this rule; and

(D) A Workers' Compensation insurer and a certified managed care system may also enter into an agreement specifying the terms and conditions associated with the use of the managed care system.

(2) For purposes of this rule, the term certified managed care system or system shall mean medical care cost containment arrangements such as preferred provider organizations (PPOs), health maintenance organizations (HMOs) and other direct employer/provider arrangements designed to provide incentives to medical care providers to manage the cost and utilization of care associated with claims covered by Workers' Compensation insurance, which have been approved by the department. The approval criteria for PPO arrangements are set forth in section (3) of this rule. The approval criteria for non-PPO arrangements shall be developed under section (8) of this rule.]

(1) Definitions.

(A) Access fee means the percentage of savings off usual and customary health care provider charges that is often charged by a managed care organization (MCO) as reimbursement for access to its network of providers.

(B) Bill re-pricing means a system for re-pricing charges for medical services to conform to levels contractually agreed to by health care providers, facilities and hospitals and through which discounted medical services are obtained.

(C) Case management means a collaborative process by which appropriately licensed and trained health care providers, coordinate, monitor and evaluate the delivery of that level of health care treatment which is necessary to assist an injured employee in reaching prompt maximum medical improvement, following prescribed medical treatment plans, and, achieving, where possible, the prompt and appropriate return to work. Case management includes "on-site case management" and "telephonic case management."

(D) Certified MCO means a workers' compensation managed care organization certified by the department.

(E) Cost savings analysis means a documentation of savings achieved through reduction of medical fees, through the use of utilization review techniques, through early employee return to work, or all of the above.

(F) Department means the Missouri Department of Insurance.

(G) Hospital bill auditing means a service designed to review the accuracy and applicability of hospital charges as well as to evaluate the medical necessity of all services and treatment rendered, which shall be considered distinct from utilization review.

(H) Insurer means any person or entity defined under sections 375.932 or 375.1002, RSMo, authorized to provide workers' compensation insurance in Missouri. The term shall include any employees, agents, third party administrators (TPAs) or others acting on behalf of such insurers.

(I) Managed care organization (MCO) means an organization, such as a preferred provider organization (PPO), a health maintenance organization (HMO) or other, direct employer/provider arrangements, designed to provide the appropriate procedures and incentives to medical providers necessary to manage the cost and utilization of care associated with claims covered by workers' compensation insurance. Unless the context clearly requires oth-

erwise, when the term MCO is used in this rule it will mean an MCO certified under the provisions of this rule.

(J) MCO administrative fee or administrative fee means any fee or charge for the reimbursement of the administrative services of an MCO, as opposed to any fee or charge for the reimbursement of a health care provider for the rendition of health care services, treatment or supplies. Such fees reimburse the MCO for the cost of organizing a network of health care providers, negotiating provider reimbursement rates, re-pricing bills, hospital bill auditing, provider bill auditing, tracking and coordinating care, pre-certification, utilization review, cost savings analysis and other MCO administrative functions. An MCO administrative fee may be in the form of an access fee, a percentage of savings off a provider's billed charges, a percentage of savings off average usual and customary fees as defined in an identified database, a dollar amount per hour, or some other method.

(K) On-site case management means case management performed in person by the case manager as the location requires.

(L) Payor means an insurer or TPA responsible for paying workers' compensation-related claim, including a bill for the fees of an MCO required to be reimbursed under this rule.

(M) Pre-certification means the process of reviewing planned nonemergency medical care to assure said care is reasonably required to cure and relieve the injured worker from the effects of the injury, as required under the Missouri Workers' Compensation Law.

(N) Provider bill auditing means a computer assisted retrospective service which verifies the accuracy and applicability of provider charges, their conformity with usual and customary charges and their conformity with any discounts from usual and customary charges or other adjustments negotiated between the provider and the MCO. Provider bill auditing also verifies causal relationships between injury and treatment, the necessity of treatment and the accuracy of medical bills prior to recommending payment.

(O) Telephonic case management means case management conducted by telephone, e-mail, or facsimile machine.

(P) TPA means a third party administrator as defined under sections 376.1075 to 376.1095, RSMo.

(Q) Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, pre-certification, concurrent review, discharge planning or retrospective review. For purposes of this rule, utilization review shall not include case management.

(2) Employer's Right to Select an MCO or Health Care Provider.

(A) A Missouri employer shall have the right to select an MCO for the purpose of providing the employer with managed care services in relation to the health care required to be provided under the Missouri Workers' Compensation Law. The employer shall have the right to select such an MCO regardless of whether that selection is approved by the employer's insurer or the selection differs from that made by the employer's insurer. Although the insurer may not require the employer to select a particular MCO, it may discuss that selection with the employer. While an employer may voluntarily agree to use an MCO under contract with the insurer if the employer so chooses, the employer may also select another MCO.

(B) An employer may select an MCO at any time during the period of the employer's insurance policy. An insurer will be deemed to have been notified of that selection whenever the insurer receives an administrative fee invoice from the MCO as defined in subsection (3)(E), attached to the bill of a health care

provider for health care services provided to an injured employee of the insured employer.

(C) Nothing in this section shall limit an employer's right to select the health care provider as authorized under subsection 10 of section 287.140, RSMo. Although the insurer may not require the employer to use a particular health care provider, it may discuss that selection with the employer. While an employer may voluntarily agree to use the providers in an MCO network under contract with the insurer if the employer so chooses, the employer may also select a provider outside a particular MCO network.

(3) Coordination and Integration of Insurer and MCO Systems.

(A) A managed care organization and an insurer shall coordinate and integrate their internal operational systems relating to claim reporting, claim handling, medical case management and billings as required under this section, unless alternative arrangements are agreed to by the MCO and the insurer.

(B) Regarding claim reporting, an employer shall report all claims to the employer's insurance company. The employer may also report any such claims to the employer's MCO.

(C) The fact that the employer has selected an MCO shall not require the employer's insurer to modify its internal claims handling procedures beyond the requirements that the insurer shall cooperate with and reimburse the providers in the MCO network selected by the employer, and shall also reimburse the MCOs for its reasonable administrative fees. The insurer shall use whatever procedures the insurer ordinarily uses for dealing with non-network providers to accomplish such cooperation and reimbursement.

(D) The employer's right to select a health care provider under section 287.140.10, RSMo extends to the employer's right to select a case management nurse, so long as the nurse is operating within the scope of his or her license.

(E) An MCO shall use a standard administrative fee invoice when billing an insurer for reimbursement. An administrative fee invoice should contain the information listed below, but shall not be deemed insufficient due to the lack of any particular pieces of information so long as the document is sufficiently clear so that an insurer can determine that the document is from an MCO and that the MCO is requesting payment for MCO services, so long as the document also provides a reasonable method for the insurer to contact the MCO for further explanation.

1. The MCO name, address, telephone number, facsimile number, federal employee identification number (FEIN); e-mail address (if available) and department MCO certification number;
2. The employer's name;
3. The injured employee's name and Social Security number;
4. The medical provider's name and FEIN;
5. The date of the medical service;
6. The provider's usual and customary charge for the service, treatment or supplies;
7. The discounted charge negotiated by the MCO for those same services, treatment or supplies;
8. The savings resulting from the MCO's discounts;
9. The administrative fee of the MCO to be paid by the insurer relating to the service, treatment or supplies in question.

(4) Criteria for Determining the Reasonableness of MCO Fees.

(A) An employer's insurer shall reimburse the reasonable administrative fees of an MCO selected by a Missouri employer if the department has certified that MCO. However, no insurer shall be required to reimburse an administrative fee charged by a department-certified MCO unless the fee is reasonable in relation to both the managed care services provided and to the savings which result from those services.

(B) Where the type of MCO administrative fee is an access fee, there shall be a rebuttable presumption that the access fee is reasonable under subsection (A) above if it is less than or equal to twenty-five percent (25%) of the difference between the health care provider's usual and customary charge for the service, treatment or supplies in question and the amount the provider has agreed to accept under his contract with the MCO.

(C) Where the type of MCO fee is not an access fee, there shall be a rebuttable presumption that the fee is reasonable under subsection (A) above if it is the standard fee charged by the MCO to other payors, when those other payors include insurers with which the MCO has formal reimbursement agreements. Where the MCO charges different payors different amounts for the fee in question under its formal reimbursement agreements with said payors, there shall be a rebuttable presumption that the lowest of these fees is reasonable under subsection (A) above.

(D) Where a particular MCO fee charged by the MCO exceeds an amount deemed reasonable under subsections (B) or (C) above, an insurer may satisfy its reimbursement obligations under this section by paying an amount which does in fact conform to the appropriate subsection.

(5) Preconditions for an Insurer's Reimbursement of an MCO's Fees.

(A) An MCO fee must meet the following preconditions, which shall be presumed to be true unless proven otherwise by the insurer:

1. Relate to an injury or illness that is compensable under Chapter 287, RSMo;
2. Relate to a medically necessary procedure or a determination of medical necessity;
3. Relate to a medical claim that has previously been reported to the insurer by the employer;
4. Relate to an employer who has a contract with the insurer for workers' compensation insurance that covers the injury or illness;
5. Be from an MCO which, on the date of the bill charge, was certified by the department;
6. Be from an MCO with which the employer has a written contract to provide MCO services;
7. Be the MCO's standard reimbursement fee for the service in question;
8. Be by means of an administrative fee invoice as required under subsection (3)(E), submitted to the insurer in connection with the underlying health care provider bill; and
9. Be reasonable under section (4) above.

(B) If an MCO administrative fee meets the requirements of subsection (A) above, an insurer shall be required to pay the MCO fee stated on the MCO administrative fee invoice.

(C) MCOs seeking reimbursement from insurers should maintain a listing of their standard administrative fees for the periods for which reimbursements are sought. Such lists should disclose the terms of the MCO's standard discounting arrangement with its health care providers and also list any administrative fees of the MCO for specific administrative functions, which may include but which are not necessarily limited to the following activities:

1. Pre-certification;
2. Prospective utilization review;
3. Concurrent utilization review;
4. Telephonic case management;
5. On-site case management;
6. Retrospective utilization review;
7. Provider bill auditing;
8. Hospital bill auditing;
9. Bill repricing; and
10. Cost savings analysis.

(D) Individual insurers and MCOs are authorized to enter into alternative reimbursement arrangements under subsection 3 of section 287.135, RSMo. Any such alternative arrangements will take precedence over the provisions of this section for the MCO and the insurer that are parties to the agreement.

(6) Procedure for Reimbursement by Insurers of MCO Fees.

(A) An MCO seeking reimbursement from an employer's insurer for its MCO services shall submit an administrative fee invoice to the insurer documenting the MCO services provided and the reimbursement requested.

(B) The insurer shall pay an MCO fee which is reasonable under section (4) above and which meets the preconditions of section (5) above.

(C) To the degree there is a dispute between an MCO and an insurer under this section, said dispute may be submitted in writing to the department for its review. The dispute shall be handled in an advisory manner by the department, after providing the parties written notice of the dispute and notice of the opposing party's allegations.

(D) An MCO may accept partial payment of an amount tendered by an insurer without prejudice to the MCO's right to the full reimbursement authorized under this rule.

(E) Where a dispute between an insurer and an MCO regarding an access fee is based on a question regarding the amount of the health care provider's underlying usual and customary charge for the service, treatment or supplies in question, the MCO may establish the provider's usual and customary charge by means of an affidavit from the provider, or a duly authorized agent of the provider, attesting to the provider's usual and customary charge for the period and for the service, treatment or supplies in question, supported by contemporaneous bills to other payors from that period for the same service, treatment or supplies in question.

(F) An insurer may produce evidence to rebut the presumptions of sections (4) and (5) above, including evidence showing that the MCO fee in question is unreasonable in relation to either the managed care services provided or to the savings which result from those services. An MCO may produce evidence in support of said presumptions. Such evidence from either party may include information regarding:

1. The extent to which the medical case involved or required oversight and coordination by the MCO;
2. The fees normally paid by the insurer to other MCOs;
3. The fees normally charged by the MCO to other insurers, and to TPAs, self-insurers and individual employers;
4. The fees normally paid by other insurers to MCOs;
5. The fees normally charged by other MCOs to insurers, TPAs, self-insurers and individual employers;
6. What the health care provider has agreed to accept from the insurer under any agreements other than the MCO agreement in question;
7. The dollar amount of the MCO fee being sought compared to the dollar amount of the underlying usual and customary charge for the service of the health care provider;
8. What an independent database indicates is a usual and customary charge for the health care service, treatment or supplies in question;
9. What a governmental database indicates is a usual and customary charge for the service, treatment or supplies;
10. The charges allowed for the treatment, service, treatment or supplies when the government is the payor;
11. What has been determined to be a reasonable provider fee by the Division of Workers' Compensation under section 287.140.3, RSMo and regulation 8 CSR 50-2.030 for the medical procedure upon which the MCO fee dispute is based, where such a determination has been made;

12. What the department has determined to be a reasonable fee in prior disputes of a similar nature; or

13. Any other information considered relevant by the department.

(G) In order to expedite its review of disputes under this rule, the department may, in its discretion or at the request of either an insurer or an MCO, consolidate separate disputes between a particular MCO and a particular insurer or insurance company holding group into a single dispute where the separate disputes concern common issues or elements.

(H) After both sides have been afforded the opportunity to present their evidence and comment on the evidence presented by the other party, the department shall review said evidence. After its review, the department shall provide the parties with a written advisory opinion of its conclusions as to the reasonableness of the fees under section 287.135, RSMo. The department's advisory opinion on its conclusions as to the reasonableness of the MCO fee shall be subject to *de novo* review by a court of competent jurisdiction pursuant to section 536.150, RSMo.

[(3)] (7) [For purposes of this rule, the term *Workers' Compensation preferred provider organization (WC/PPO)* shall mean a health care plan designed to coordinate employee care and control and contain costs for medical and rehabilitative services associated with Missouri Workers' Compensation claims through the use of special provider networks, utilization review and case management procedures.] **Department Certification of MCOs.** In order to be certified, [a WC/PPO] an MCO shall meet the following requirements:

(A) The [WC/PPO] MCO shall contract with member health care providers who are authorized to provide health care services in this state by the appropriate licensing authorities;

(B) Regarding contract requirements for medical and rehabilitative services, the [WC/PPO] MCO shall—

1. Provide for convenient access to the following types of providers in one (1) or more Missouri counties or cities not within a county:

- A. Primary care physicians;
- B. Subspecialty physicians;
- C. Rehabilitation centers; and
- D. Hospitals;

2. Provide for convenient access to primary care clinics which are specialized in providing occupational medical services;

3. Employ a medical director who is board-certified in occupational medicine or who possesses considerable experience with Missouri's workers' compensation system; and

4. Possess the capability for progressive rehabilitation services, including, but not limited to:

- A. Functional, objective capacity evaluations;
- B. Psychological testing; and
- C. Work hardening;

(C) Regarding additional [WC/PPO] MCO contract requirements, the [WC/PPO] MCO shall—

1. Provide employers with job-site presentations or other presentations regarding how to make proper use of the managed care services of the organization;

2. Base charges on negotiated rates of reimbursement to providers for the services specified in paragraph [(3)] (7)(B)1. comparable to the best group medical plans in the geographic market area served, including provisions for basing inpatient services charges on diagnosis-related group (DRG) rates;

3. Include the prepricing of claims;

4. Provide monthly reports, on a claim-by-claim basis, specifying customary charges, charges allowed under the [WC/PPO] MCO contract and the resulting savings, if any; [and]

5. Provide for the external management and oversight from the initial date of injury by a nonhealth care provider of the health care provider's rendition of medical care in all cases; and

6. Provide for an internal dispute resolution procedure that meets the requirements of subsection 2 of section 287.135, RSMo; and

(D) Be in addition, under the management and control of officers and directors who are competent to manage the [WC/PPO] MCO-managed health care operations, its finances, its compliance with agreements between itself and insurers or employers, or both, and its compliance with any applicable laws of Missouri.

[(4)] **(8) Certification Procedure.**

(A) For purposes of obtaining the department's certification of a [WC/PPO] MCO, the organization shall provide the department with the following materials:

1. Copies of any [PPO] MCO/employer and [PPO] MCO/insurer contracts to be used;
2. A general diagram of the [WC/PPO's] MCO's organizational structure;
3. A listing of the [WC/PPO's] MCO's officers and directors;
4. The [WC/PPO's] MCO's most recently audited financial report;
5. A thorough description of the [WC/PPO's] MCO's experience with the management of health care costs associated with Workers' Compensation claims and with other health care claims;
6. The geographic area, by county, the [WC/PPO] MCO plans to serve;
7. A copy of the licenses and any certificates of the [board-certified] medical director;
8. A complete list of all primary care physicians, subspecialist physicians, rehabilitation centers, hospitals and work hardening centers to be employed by the organization;
9. The estimated savings to employers and insurers from the use of the organization;
10. The outline of the operation of the [WC/PPO] MCO to be provided to employers explaining their rights and responsibilities; *[and]*

11. The MCO's dispute resolution procedures; and

[(11)] **12.** Any other materials requested by the director.

(B) The materials specified in subsection *[(4)](8)(A)* shall be retained by the department. Any significant changes to the nature of the [WC/PPO's] MCO's operations as reflected in these materials shall be reported to the department, but these reports need not be made more than twice a year, as measured from the date of the granting of any certification.

(C) The department shall review these documents and grant certification, on the form contained in Exhibit I of this rule, **included herein**, to those [WC/PPOs] MCOs deemed to meet the criteria set forth in this rule. Any departmental decision to deny certification shall be accompanied by a written explanation by the department of the reasons for denial.

(D) The department may suspend or revoke the certification of a [WC/PPO] MCO at any time it establishes that the criteria set forth in this rule are no longer being met. Any such organization may request a hearing before the director on that suspension or revocation.

(E) MCOs previously certified need not be re-certified during the period of this rule.

[(5)] Insurers writing Workers' Compensation insurance in Missouri may contract with a certified managed care system. This contract may cover all employers insured by the insurer in the state, any class or subclass of employers, any employers located in a particular geographic region, or on any other basis which does not result in unfair discrimination under section 375.936(11), RSMo. Any employers who participate in this arrangement shall execute the contract required in subsection (1)(B) of this rule. For purposes of encouraging its insured employers to use a managed care system with which it has contracted, an insurer may offer

premium reductions in excess of those required in section (1) of this rule. Nothing shall preclude an insurer from discussing the relative merits of different managed care systems with its insureds.

(6) Where an insurer has not contracted with a certified managed care system in a given geographic region, but that a system does operate in that region, upon a request by an insured employer, the insurer shall provide the insured the premium reduction specified in section (1) of this rule so long as the certified system is willing to provide health care services to the employer. The insurer, however, may apply the five percent (5%) premium reduction specified in section (1) only to that portion of the employer's operations occurring in the geographic regions served by the certified system.

(7) Nothing contained in this rule shall be interpreted as precluding an employer from taking advantage of other noncertified managed care options at his/her own expense, particularly where the employer's operations are located outside the geographic territory of a certified managed care system. The use of this system, however, shall not entitle the employer to a premium reduction by its insurer.

(8) The director shall establish an informal task force for fostering the widest possible use of managed care systems in Missouri in relation to Workers' Compensation insurance. The task force may consist of volunteers representing insurers, managed care providers, employers and other interested parties. The task force will assist the department in developing approval criteria for approving additional managed care systems in Missouri. The panel will assist the director in developing approval criteria for PPOs that do not meet the criteria of section (3) of this rule, and of other managed care systems such as HMOs and direct employer/provider contracts, and the appropriate level of premium discount to be associated with these systems. They also may assist in the development of performance standards to measure the effectiveness of all managed care systems associated with Workers' Compensation insurance. All meetings of the advisory panel will be subject to the state's open meetings law.

(9) An insurer need provide a premium discount to an insured employer only for a three (3)-year period, after which time any reduction in the employer's premium as a result of the use of managed care services shall be reflected in the employer's experience modification factor. An employer shall not be entitled to more than three (3) years of specified premium reductions by reason of changing insurers, changing managed care systems or changing the ownership of the employer. Change of ownership rules regarding employers approved by the department concerning Workers' Compensation shall apply to these cases.]

(9) Termination Date. This rule shall terminate December 31, 2002.

Exhibit I

Certificate of Authority

Managed Care System for Workers' Compensation

It is Hereby Certified That

(Enter name of Managed Care Organization)

meets the certification requirements of Section 287.135 of the Revised Statutes of Missouri and Regulation 20 CSR 500-6.700. (Enter name of MCO) has been assigned the following departmental identification number: MCO No. XX.

This certificate shall remain in full force and effect until suspended or revoked by the Director.

IN WITNESS WHEREOF, I have hereto set my hand and caused to be hereto affixed the Seal of said Department. Done in my office in the City of Jefferson, this (Enter date).

Director of Insurance

*AUTHORITY: sections 287.135 [287.320, RSMo Supp. 1992] and 374.045, RSMo [1986] 2000. Emergency rule filed Aug. 31, 1992, effective Nov. 1, 1992, expired Feb. 28, 1993. Original rule filed April 14, 1992, effective Feb. 26, 1993. Amended: Filed May 3, 2002. Emergency amendment filed Sept. 16, 2002, effective Sept. 26, 2002, expires Dec. 31, 2002. An order of rulemaking on a proposed amendment covering this same material will be published in the **Missouri Register**.*