Rules of
Department of Insurance
Division 400—Life, Annuities and Health
Chapter 10—Health Carrier Utilization Review Activities

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Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 10—Health Carrier Utilization Review Activities

20 CSR 400-10.010 Requirements of Utilization Review Program Documents

PURPOSE: This rule defines the contents of written utilization review program documents required of certain health carriers by section 376.1359, RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997).

(1) The written utilization review program document required of health carriers by section 376.1359.1, RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), for plans containing a managed care component shall describe—

(A) Policies, processes and procedures which govern all aspects of the utilization review process, including but not limited to:

1. Scope and objectives;
2. Program organization;
3. Monitoring and oversight mechanisms;
4. Evaluation and organizational improvement of clinical review activities; and
5. Delegation of responsibility for utilization review activities;

(B) Policies, processes and procedures to ensure that patient-specific information collected during the utilization review process—

1. Is kept confidentially in accordance with applicable federal and state laws; and
2. Is limited to that information necessary for utilization review of the services under review;

(C) Policies, processes and procedures concerning utilization review decision criteria which—

1. Require the utilization review decision to be in writing;
2. Document the clinical utilization review criteria used;
3. Require utilization review criteria to be based on sound clinical evidence;
4. Provide for periodic evaluations of the utilization review decision criteria to assure ongoing efficacy; and
5. Coordinate the utilization review program with other medical management activities conducted by the health carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for accessing member satisfaction and risk management;

(D) Policies requiring the medical director administering the program to be a qualified health care professional licensed in the state of Missouri;

(E) The utilization review decision-making policies, processes, and procedures including, but not limited to, those that ensure:

1. Decisions are made in a timely manner as required by sections 376.1363, 376.1365 and 376.1367, RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997);
2. The health carrier obtains all information required to make utilization review decisions, including pertinent clinical information;
3. Utilization reviewers apply clinical review criteria consistently;
4. Adverse determinations are evaluated by a clinical peer, licensed in any state, as to appropriateness, either before or after the determination is made;
5. Timely access to review staff is provided to enrollees and providers by means of a toll-free number;
6. Enrollees or providers on behalf of enrollees may appeal for coverage of medically necessary pharmaceutical prescriptions and durable medical equipment as part of the process; and
7. Compliance with section 376.1367, RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), concerning emergency services;

(F) The data systems used in utilization review program activities and the manner in which the health carrier measures the system's ability to generate management reports to enable the health carrier to monitor and manage health care services effectively;

(G) All policies, processes and procedures whereby the health carrier maintains oversight of utilization review activities delegated to a utilization review organization, including:

1. Those ensuring that appropriate personnel have operational responsibility for the conduct of the utilization review program;
2. Those ensuring the utilization review organization complies with sections 376.1350 to 376.1390, RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997);
3. A description of the utilization review organization's activities and responsibilities, including reporting requirements; and
4. Those by which the health carrier evaluates the performance of the utilization review organization;

(H) All processes and procedures for making, reconsidering and appealing utilization review determinations;

(I) All processes and procedures for notifying enrollees and providers acting on behalf of the enrollees, and any other party entitled to notice, of—

1. The health carrier's determinations;
2. Instructions for initiating an appeal or reconsideration; and
3. Instructions for requesting a written statement of the clinical rationale, including the review criteria, used to make the determination; and

(J) All policies and procedures addressing the failure or inability of a provider or an enrollee to provide all necessary information for review.

(2) A health carrier may satisfy the requirements of section (1) by implementing the most recent utilization review program document it has submitted to either the Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurance (NCQA) for certification, or to any similar entity, but only if—

(A) The utilization review program document submitted for accreditation is supplemented to include the information required by section (1); and

(B) The utilization review program document reflects current policies, processes and procedures which the health carrier applies to the plan.

AUTHORITY: sections 374.045 and 376.1359, RSMo Supp. 1997. Original rule filed Nov. 3, 1997, effective June 30, 1998.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 376.1359, RSMo 1997.*

20 CSR 400-10.020 Annual Reporting Requirements for Health Carriers Regarding Utilization Review Activities

PURPOSE: This rule sets forth the reporting requirements of health carriers, pursuant to sections 376.1359, 376.1369 and 376.1378, RSMo, found in H.B. 335, 1997, regarding utilization review activities.

(1) All health carriers which market health care plans which have a managed care component shall make the following report regarding utilization review activities to the director, annually, on or before March 1:

(A) Where the health carrier is acting as a utilization review agent, the health carrier shall file a report of its utilization review activities, which report shall include a summary of the types of utilization review activities and any other information the director may require;

(B) Where the health carrier has contracted with an outside utilization review organization, or otherwise delegated its utilization review activities, the health carrier shall file a report of the utilization review activities,

which report shall include a summary of the types of utilization review activities and a list of the entities or organizations conducting the utilization review activities, including the address of the utilization review agent or organization used; and

(C) The director may allow a health carrier to file, in lieu of the report otherwise required, a copy of a health carrier's report to another agency, provided such report contains the information required by this rule.

(2) All health carriers shall include in the report required by section (1) of this rule, a written certification, pursuant to section 376.1369, RSMo, H.B. 335, 1997, that the utilization review program of the health carrier or its designee complies with all applicable state and federal laws that establish confidentiality and reporting requirements.

(3) All health carriers or its designee shall include in the report required by section (1) of this rule a copy of the grievance procedures and all forms for the processing of grievances used by the health carrier or its designee. Where these documents are already on file with the director, the health carrier shall file, as a part of the report required by section (1) of this rule, all material modifications made to the grievance procedures or forms.

(4) All health carriers or its designee as a part of the report required by section (1) of this rule, shall file a written certification of compliance, pursuant to section 376.1378, RSMo, H.B. 335, 1997, stating that the health carrier or its designee has established and maintained, for each of its benefit plans, grievance procedures that fully comply with the provisions of sections 376.1350 to 376.1390, RSMo, H.B. 335, 1997.

AUTHORITY: sections 354.485, 374.045 and 374.515, RSMo 1994 and 376.1359, 376.1369, 376.1378 and 376.1399, RSMo Supp. 1997. Original rule filed Nov. 3, 1997, effective May 30, 1998.*

**Original authority: 354.485, RSMo 1983; 374.045, RSMo 1967, amended 1993; 374.515, RSMo 1991, amended 1993; 376.1359, 376.1369 and 376.1378, RSMo 1997; and 376.1399, RSMo 1997, amended 1997.*

20 CSR 400-10.100 Minimum Time Allowed for a Consumer to File a Grievance

PURPOSE: This rule sets forth the minimum amount of time a health carrier that offers a managed care plan can require an enrollee or member to file an appeal. This rule is promulgated pursuant to section 376.1399, RSMo, and implements sections 376.1382 and 376.1385, RSMo.

(1) Definitions.

(A) "Adverse determination" shall have the same meaning as found in section 376.1350, RSMo.

(B) "Grievance" shall have the same meaning as found in section 376.1350, RSMo.

(C) "Health carrier" shall have the same meaning as found in section 376.1350, RSMo.

(D) "Managed care component" shall mean a plan that offers an incentive to use specific providers or requires the use of utilization review.

(E) "Utilization review" shall have the same meaning as found in section 376.1350, RSMo.

(2) Minimum Time to File a Grievance.

(A) No health carrier that offers a plan with a managed care component shall limit the time that a first level grievance may be filed to less than one hundred eighty (180) days from the date that written notice was sent from the health carrier to the enrollee informing the enrollee of the adverse determination.

(B) In the case of a grievance filed for reasons other than an adverse determination, the health carrier shall not limit the time a first level grievance may be filed to less than one hundred eighty (180) days from the date the health carrier sent notice to the enrollee informing the enrollee of the event that gave rise to the grievance.

(C) No health carrier that offers a plan with a managed care component shall limit the time that a second level grievance may be filed to less than one hundred eighty (180) days from the date the carrier allows to file the first level grievance or less than one hundred eighty (180) days from the date the health carrier sent notification to the person who submitted the grievance of the carrier's resolution of said first level grievance, whichever is later.

(D) Nothing in this section shall limit or supersede any statute of limitations found in the *Revised Statutes of Missouri*.

AUTHORITY: sections 374.045 and 376.1399, RSMo 2000. Original rule filed May 2, 2005, effective Dec. 30, 2005.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 376.1399, RSMo 1997, amended 1997.*

20 CSR 400-10.200 Authorization For Health Care Services Not To Be Withdrawn After the Services Have Been Provided, Exceptions

PURPOSES: This rule interprets sections 376.1350(4), 376.1359, 376.1361.12 and 376.1361.13, RSMo Supp. 1997.

(1) Utilization review by health carriers for plans containing a managed care component is performed only for covered services, section 376.1359, RSMo Supp. 1997. Therefore, a benefits determination must be performed prior to utilization review under sections 376.1350(4), 376.1361.12 and 376.1361.13, RSMo Supp. 1997. Because a benefits determination must be made prior to utilization review, certification will be deemed to be an authorization of a covered benefit. If an authorized representative of a health carrier authorizes the provision of a health care service, the health carrier shall not subsequently retract its authorization after the health care service has been provided, or reduce payment for an item or service furnished in reliance on approval, unless—

(A) Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or

(B) The health benefit plan terminates before the health care services are provided; or

(C) The covered person's coverage under the health benefit plan terminates before the health care services are provided.

(2) Where a health carrier has authorized the provision of a health care service and a dispute arises between the health carrier and the provider after the service is rendered concerning whether the provider provided the service in a manner or type authorized by the health carrier, the health carrier must hold the enrollee harmless from claims made against the enrollee by the provider concerning the service, except for applicable copayments, coinsurance and deductibles. Failure to hold the enrollee harmless will be deemed a violation of section 376.1361.13, RSMo as an indirect retraction of the authorization. Notwithstanding any provision of this rule, sections 376.1350–376.1390, RSMo Supp. 1997, do not determine or allocate the responsibility for utilization review decisions as between the health carrier and providers.

AUTHORITY: section 374.045.1, RSMo Supp. 1997. Original rule filed Jan. 6, 1998, effective July 30, 1998.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995.*

20 CSR 400-10.250 Electronic Confirmation of Utilization Review Determinations Deemed Made When

PURPOSE: This rule describes the conditions under which an electronic notice of a utilization review determination will be deemed to have been made.

(1) When a health carrier is required by section 376.1363, RSMo, H.B. 335 (First Regular Session of the 89th General Assembly 1997), to provide written or electronic confirmation of its utilization review determinations to providers, enrollees or certificate holders (enrollees and certificate holders hereinafter collectively referred to as enrollees), for plans containing a managed care component, an electronic confirmation will be deemed by the department to have been made if the confirmation is available to the provider and enrollee on an interactive voice response telephone system or other electronic notification system which is universally accessible and compatible with the Telecommunication Device for the Deaf, if—

(A) The system has a security component to prevent enrollees' confidential information from being accessed by unauthorized individuals; and

(B) The confirmation can be accessed by the enrollee and the enrollee's provider for a minimum of sixty (60) days after the determination is made; and

(C) Written confirmation of the determination may be requested by the enrollee or provider by means of the system; and

(D) All requests made by enrollees and providers for written confirmation are honored within the time limits imposed by section 376.1363, 376.1365 or 376.1367, RSMo Supp. 1997; and

(E) The system may be accessed by enrollees and providers by means of a toll-free number; and

(F) All determinations and notifications are archived by the health carrier for a period of three (3) years after the determinations are made.

AUTHORITY: section 374.045.1, RSMo Supp. 1997. Original rule filed Nov. 3, 1997, effective June 30, 1998.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995.*