Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 30—Bingo

PROPOSED AMENDMENT

11 CSR 45-30.190 Rules of Play. The commission is amending section (1).

PURPOSE: The purpose of the amendment is to clarify that no bingo paper or pull-tab sales may begin prior to 10:00 a.m. pursuant to 313.040(14), RSMo.

(1) Except for pull-tab games, a bingo game begins with the first letter and number drawn (called). Bingo paper may be sold no more than two (2) hours prior to the start of the first bingo game**; however, no bingo paper or pull-tab sales may start before 10:00 a.m**. The paper and/or pull-tab sales time must be clearly posted in the licensee's house or game rules. All bingo paper and/or pull-tab sales times are subject to approval by the commission.

*AUTHORITY: section 313.065, RSMo [Supp. 1998] **2000**. Emergency rule filed June 21, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency rule filed Oct. 19, 1994, effective Oct. 29, 1994, expired Feb. 25, 1995. Original rule filed July 11, 1994, effective Jan. 29, 1995. Amended: Filed Dec. 12, 1997, effective July 30, 1998. Amended: Filed May 13, 1998, effective Dec. 30, 1998. Amended: Filed Oct. 29, 1999, effective May 30, 2000. Amended: Filed Oct. 1, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Public Safety, Missouri Gaming Commission, Bingo Division, PO Box 1847, 3417 Knipp Drive, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. Private entities who feel there is cost which exceeds five hundred dollars ($500) associated with this rule, are requested to submit the cost (estimated or actual, if available) with the comments. Public hearing is scheduled for 10:00 a.m. on December 11, 2001, in the Gaming Commission's hearing room located at 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 30—Bingo

PROPOSED AMENDMENT

11 CSR 45-30.395 Manufacturer Record Keeping Requirements. The commission is amending section (1), adding a new section (3), renumbering the remaining sections and amending the new section (6).

PURPOSE: The purpose of the amendment is to clarify the record keeping requirements for manufacturers.

(1) A manufacturer shall maintain copies of all sales invoices. Invoices shall include name of manufacturer, manufacturer's Missouri license number, name and license number of the Missouri supplier, invoice number, full description of bingo equipment/merchandise shipped, serial number of equipment/merchandise**, shipping destination** and date equipment/merchandise was shipped.

(3) All documents generated by the manufacturer with each product sold must also be maintained. Documents such as order forms, bills of lading or other documents must be retained with the invoice.

*[(3)]***(4)** In packaging the bingo paper or pull-tabs, the manufacturer shall comply with the following packaging requirements:

(A) Each package, box or container shall be sealed; and

(B) The serial number shall be placed on the outside of the package so that it can be clearly viewed from the outside.

*[(4)]***(5)** All records, reports and receipts required by this rule and Chapter 313, RSMo shall be maintained for a minimum of three (3) years and stored in such a manner as to be available for inspection by the commission upon request at no charge.

*[(5)]***(6)** Manufacturers are only allowed to sell their *[products]* **bingo equipment, as defined in 11 CSR 45-30.155, in the state of Missouri** to suppliers licensed by the commission. If violations of this restriction or other restrictions listed in this rule, or Chapter 313, RSMo are identified by the commission, the manufacturer**'**s license could be subject to immediate suspension or revocation.

*AUTHORITY: section 313.065, RSMo [Supp. 1996] **2000**. Original rule filed Dec. 15, 1994, effective May 28, 1995. Amended: Filed July 3, 1995, effective Jan. 30, 1996. Amended: Filed Aug. 5, 1996, effective March 30, 1997. Amended: Filed Oct. 1, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Public Safety, Missouri Gaming Commission, Bingo Division, PO Box 1847, 3417 Knipp Drive, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. Private entities who feel there is cost which exceeds five hundred dollars ($500) associated with this rule, are requested to submit the cost (estimated or actual, if available) with the comments. Public hearing is scheduled for 10:00 a.m. on December 11, 2001, in the Gaming Commission's hearing room located at 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 30—Bingo

PROPOSED AMENDMENT

11 CSR 45-30.525 Supplier Record Keeping Requirements. The commission is amending section (8).

PURPOSE: The purpose of the amendment is to clarify the sale of bingo paper to entities not required to be licensed by the commission.

(8) Suppliers are only allowed to buy bingo products from licensed Missouri manufacturers and are only allowed to sell bingo products to licensed Missouri suppliers or operators. **Suppliers may, however, sell bingo paper to entities who are not licensed with the commission, if the paper is used for a free, no-charge bingo game. Prior approval must be obtained from the commission by the entity that is going to use the bingo paper. The supplier must maintain a copy of the approval with the original invoice. The paper must be marked as prescribed by the commission, to reflect the paper may not be used in conjunction with a licensed bingo game.** Suppliers are allowed to sell products tax free to suppliers or operators in other states (export sales), if the record keeping requirements listed in sections (2)–(4) of this rule are followed. **Suppliers shall maintain a separate invoice file for all Missouri tax-exempt sales.** If violations of this restriction or the other restrictions listed in this rule or Chapter 313, RSMo are identified by the commission, the supplier's license could be subject to immediate suspension or revocation.

*AUTHORITY: section 313.065, RSMo [Supp. 1998] **2000**. Emergency rule filed Dec. 15, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed May 2, 1995, effective May 12, 1995, expired Sept. 8, 1995. Original rule filed Feb. 16, 1996, effective Aug. 30, 1996. Amended: Filed May 6, 1999, effective Dec. 30, 1999. Amended: Filed Oct. 1, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Public Safety, Missouri Gaming Commission, Bingo Division, PO Box 1847, 3417 Knipp Drive, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. Private entities who feel there is cost which exceeds five hundred dollars ($500) associated with this amendment, are requested to submit the cost (estimated or actual, if available) with the comments. Public hearing is scheduled for 10:00 a.m. on December 11, 2001, in the Gaming Commission's hearing room located at 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 70—Division of Liquor Control
Chapter 3—Tobacco Regulations

PROPOSED RULE

11 CSR 70-3.010 Retailer Employee Tobacco Training Criteria

PURPOSE: This rule establishes training criteria for retailers and employees selling tobacco products.

(1) Minimum retailer employee tobacco training, as referenced in section 407.931.6, RSMo, shall not exceed a total of ninety (90) minutes in length and shall cover the following criteria:

(A) State laws set out in sections 407.926, RSMo, et seq.;

(B) Federal regulations pertaining to retail sales of tobacco products, set out in 21 CFR Part 897;

(C) What constitutes a valid identification as set out in section 407.929.2, RSMo;

(D) How to determine the validity of an identification and to detect fake, invalid and/or altered identifications; and

(E) The refusal and denial of the sale of tobacco products to a minor or to someone without proper identification.

(2) An owner of an establishment where tobacco products are available for sale may claim the exemption of section 407.931.6, RSMo if said owner had in place an in-house or other tobacco compliance employee training program meeting the criteria in section (1) above and the training was attended by all employees who sell tobacco products to the general public.

(3) Each employee attending the training shall sign and date a certification upon completion of the training stating that the employee has been trained and understands the state laws and federal regulations regarding the sale of tobacco products. This certification shall be presented to the supervisor of liquor control upon request.

AUTHORITY: section 407.931.6(3), RSMo Supp. 2001. Original rule filed Sept. 27, 2001.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately nine hundred thousand dollars ($900,000) annually.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to the proposed rule with the Division of Liquor Control, Charles R. Jackson, Acting State Supervisor, PO Box 837, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I RULE NUMBER

Title: 11 Department of Public Safety
Division: 70 Division of Liquor Control
Chapter: 3 Tobacco Regulations
Type of Rulemaking: Proposed Rule
Rule Number and Name: 11 CSR 70-3.010 Retailer Employee Tobacco Training Criteria

II SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Approximately 12,000	Retail outlets that sell tobacco products	$900,000 annually

III WORKSHEET

We estimate that there are 12,000 retailers in Missouri who sell tobacco products. We also estimate that seventy-five percent of these 12,000 tobacco retailers will train their employees in accordance with this proposed rule. Also, it is estimated that the average cost per retailer will be $100 annually to maintain training for all employees. Therefore, the estimated annual cost is $900,000 (12,000 retailers x 75% x $100 = $900,000).

IV ASSUMPTIONS

Annual cost to private entities is based on the assumption that 9,000 of the 12,000 tobacco retailers will elect to train employees as delineated in this proposed rule at a cost of $100 annually. These are not mandatory training criteria; however, tobacco retailers must train employees in accordance with the proposed rule to use the exemption from disciplinary action for selling tobacco to minors under Section 407.926, RSMo.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 70—Division of Liquor Control
Chapter 3—Tobacco Regulations

PROPOSED RULE

11 CSR 70-3.020 Guidelines for Sting Operations

PURPOSE: This rule establishes guidelines for the use of minors in tobacco investigations by a state, county, municipal or other local law enforcement authority.

(1) The following shall constitute guidelines for the use of minors in tobacco investigations by a state, county, municipal or other local law enforcement authority:

(A) The minor shall be seventeen (17) years of age;

(B) The minor shall have a youthful appearance, and the minor, if a male, shall not have facial hair or a receding hairline and, if a female, shall not wear excessive makeup or excessive jewelry;

(C) The state, county, municipal or other local law enforcement agency shall obtain the consent of the minor's parent or legal guardian before the use of such minor on a document in the following form:

Parent/Legal Guardian Authorization and Consent

State of Missouri)
COUNTY of _____)

Before me, the undersigned authority, on this _____ day of _____, 20_____, personally appeared_____, who by me is known and who after being by me first duly sworn did depose and state:

1. I am the mother/father/legal guardian of _____, a minor, and said minor was born on the _____ day of_____, 19____.
2. I do hereby give consent for my said minor child to assist the _____ in the investigation of offenses involving the unlawful sale of tobacco products in this state. I understand that my child will be entering locations in which tobacco products are sold and that my child will attempt to purchase tobacco products, but only under the direction and supervision of agents of the _____.
3. I understand that my child may wear an audio recording or transmitting device which will record or transmit oral conversations while my child is attempting the purchase of tobacco products, and I consent to my child wearing such. I also consent to the video recording of my child's activities during these attempts.
4. I understand and agree that my child may be required to appear and testify in court and/or in an administrative proceeding concerning the purchase of tobacco products or other criminal or administrative violations and that said appearance and testimony may be required in Jefferson City or another location in this state.

_____
Signature

_____
Print Name

Sworn to and subscribed before me this _____day of _____, 20___

_____
Notary Public

(D) The state, county, municipal or other local law enforcement agency shall make a photocopy of the minor's valid identification showing the minor's correct date of birth;

(E) Any attempt by such minor to purchase tobacco products shall be videotaped or audiotaped with equipment sufficient to record all statements made by the minor and the seller of the tobacco product;

(F) The minor shall carry his or her own identification showing the minor's correct date of birth and shall, upon request, produce such identification to the seller of the tobacco product, and the state, county, municipal or other local law enforcement agency shall search the minor prior to the operation to ensure that the minor is not in possession of any other valid or fictitious identification;

(G) The minor shall answer truthfully any questions about his or her age and shall not remain silent when asked questions regarding his or her age;

(H) The minor shall not lie to the seller of the tobacco product to induce a sale of tobacco products;

(I) The minor shall not be employed by the state, county, municipal or other local law enforcement agency on an incentive or quota basis;

(J) If a violation occurs, the state, county, municipal or other local law enforcement agency shall, within two (2) hours, make reasonable efforts to confront the seller with the minor, if practical, and further, within forty-eight (48) hours, contact or take all reasonable steps to contact the owner or manager of the establishment;

(K) The state, county, municipal or other local law enforcement agency shall maintain records of each visit to an establishment where a minor is used by the state, county, municipal or other local law enforcement agency for a period of at least one (1) year following the incident, regardless of whether a violation occurs at each visit, and such records shall, at a minimum, include the following information:

1. The signed consent form of the minor's parent or legal guardian;

2. A Polaroid photograph of the minor taken immediately prior to the operation;

3. A photocopy of the minor's valid identification, showing the minor's correct date of birth;

4. An Information and Consent document completed by the minor in advance of the operation in the following form:

Minor Information and Consent

State of Missouri)
COUNTY of _____)

Before me, the undersigned authority, on this _____ day of _____, 20_____, personally appeared_____, who by me is known and who after being by me first duly sworn did depose and state:

1. I am _____, a minor, and was born on the _____ day of_____, 19____
My address is _____.
My driver's license number is _____ in the State of _____.
My Social Security number is _____.
My parents'/legal guardians' names are _____.
My home telephone number is _____.

2. I do hereby agree to assist the _____ in the investigation of offenses involving the unlawful sale of tobacco products in this state. I understand that I will be entering locations in which tobacco products are sold and that I will attempt to purchase tobacco products, but only under the direction and supervision of agents of the _____ _____.

3. I understand that I may wear an audio recording or transmitting device which will record or transmit oral conversations while I am attempting the purchase of tobacco products, and I consent to wearing such. I also consent to the video recording of my activities during these attempts.

4. I understand and agree that I may be required to appear and testify in court and/or in an administrative proceeding concerning the purchase of tobacco products or other criminal or administrative violations and that said appearance and testimony may be required in Jefferson City or another location in this state.

_____
Signature

_____
Print Name

Sworn to and subscribed before me this _____day of _____, 20___.

_____
Notary Public

5. The name of each establishment visited by the minor, and the date and time of each visit;

6. The audiotape or videotape specified in subsection (1)(E) above; and

7. A written Minor Report in the following form:

Minor Report

Date of Purchase: _____ Time of Purchase: _____a.m./p.m
Name of Establishment: _____
Address: (street and city) _____ (County)_____
Approximate Age of Seller: _____ Sex of Seller: _____
Hair Color of Seller: _____ Clothing of Seller: _____
Sellers' Actions (did or did not ask for I.D.): _____
Description of Product and Brand Purchased: _____
Quantity: _____ Price: _____
Conversation with Seller: _____
Other Details: _____

_____
Minor's Signature

(L) The state, county, municipal or other local law enforcement agency must provide pre-recorded currency to the minor, to be used in the operation, and, if a violation occurs, must make all reasonable efforts to retrieve the pre-recorded currency. If a violation occurs, said agency shall further secure and inventory any tobacco products purchased; and

(M) The state, county, municipal or other local law enforcement agency must, in advance of the operation, train the minor who will be used in the operation, which training shall, at a minimum, include i) instruction to enter the designated establishment and to proceed immediately to attempt to purchase tobacco products; ii) instruction to provide the minor's valid identification upon a request for identification by the seller; iii) instruction to answer truthfully all questions about age; iv) instruction not to lie to the seller to induce a sale of tobacco products; v) instruction on the use of pre-recorded currency; and vi) instruction on the other matters set out in this regulation.

AUTHORITY: section 407.934.5, RSMo Supp. 2001. Original rule filed Sept. 27, 2001.

PUBLIC COST: This proposed rule is expected to cost state agencies and political subdivisions a total of seventy-two thousand seven hundred dollars ($72,700) for one time start-up costs. A fiscal note containing detailed estimated costs of compliance has been filed with the secretary of state.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Division of Liquor Control, Charles R. Jackson, Acting State Supervisor, PO Box 837, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC ENTITY COST

I RULE NUMBER

Title: 11 Department of Public Safety
Division: 70 Division of Liquor Control
Chapter: 3 Tobacco Regulations
Type of Rulemaking: Proposed Rule
Rule Number and Name: 11 CSR 70-3.020 Guidelines for Sting Operations

II SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Division of Liquor Control	$1,200 one time cost
715 Missouri Law Enforcement Agencies	$71,500 one time cost

III WORKSHEET

1. These guidelines require the attempted purchase of tobacco products by the minor to be videotaped or audiotaped. The estimated cost for the Division of Liquor Control is based on the purchase of 12 voice-activated audiotape recorders at $100 each (12 x $100 = $1,200) to be used in tobacco investigations.

2. The estimated cost for law enforcement agencies is based on each of 715 agencies purchasing voice activated audiotape recorders (715 x $100 = $71,500).

IV ASSUMPTIONS

1. Each of the Division of Liquor Control's six district offices will need two pieces of audiotape recording equipment at a cost of $100 per recorder.

2. Each of the 715 Missouri law enforcement agencies will need audiotape recording equipment at a cost of $100 per recorder.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.275 Recognition of Nonresident Disabled Person Windshield Placards. The director proposes to amend the purpose and section (1).

PURPOSE: This amendment is necessary due to the passage of Senate Bill 111, 91st General Assembly that requires the Department of Revenue to recognize federally issued disabled emblems for vehicles.

PURPOSE: This rule sets forth the criteria by which Missouri will recognize and honor vehicles displaying disabled person windshield placards ***or disabled emblems*** *issued to* ***resident or*** *nonresident operators of these vehicles by* ***the United States government,*** *another state, District of Columbia, or territory or possession of the United States [of which the operator is a resident].*

(1) Missouri shall honor disabled person windshield placards **or federally issued disabled emblems** displayed in or on vehicles of **resident or** nonresident operators at all times when the vehicles are operated by **residents or** nonresidents within this state and specifically when the vehicles are located in parking spaces designated for the disabled. The following conditions apply:

(C) Nothing in this rule, in any way, shall be interpreted to allow a **resident or** nonresident operator of a vehicle displaying a disabled person windshield placard **or federally issued disabled emblem** to violate any **state statute or** lawful political subdivision's ordinances governing parking of vehicles within the boundaries of the political subdivision.

*AUTHORITY: sections 301.271, RSMo [1986] **2000** and 301.142, RSMo [Supp. 1991] **SB 111, 91st General Assembly, 1st Regular Session 2001**. Original rule filed April 21, 1986, effective Aug. 11, 1986. Amended: Filed Nov. 12, 1991, effective March 9, 1992. Amended: Filed Sept. 27, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED AMENDMENT

12 CSR 10-24.050 Deletion of Traffic Convictions and Suspension or Revocation Data From Missouri Driver Records. The director proposes to amend section (1).

PURPOSE: This proposed amendment includes deletion criteria for suspensions for theft of motor fuel.

(1) The Department of Revenue, when otherwise not prohibited by law, may delete from a Missouri driver record a previously recorded traffic conviction, suspension or revocation of a driving privilege if all of the following conditions are met:

(E) The suspension or revocation on the driver record did not involve an alcohol-related offense or enforcement contact; except when the offense was committed by a person under the age of twenty-one (21), who had a blood alcohol content of .02 *[through .099]* **or more** and an expungement of the records is provided for in section 302.545, RSMo;

(F) The suspension on the driver record did not involve the theft of motor fuel as provided in section 302.286, RSMo;

[(F)] **(G)** The driver record does not contain information regarding the mental or physical competence of the individual to retain a drivers license; and

[(G)] **(H)** The driver record is not currently under investigation.

*AUTHORITY: sections **302.286,** 302.304, 302.309 and 303.041, RSMo Supp. [1999] **2001**. Original rule filed May 27, 1986, effective Aug. 25, 1986. Amended: Filed Sept. 8, 1989, effective Jan. 26, 1990. Amended: Filed Jan. 31, 1992, effective June 25, 1992. Amended: Filed Nov. 4, 1999, effective May 30, 2000. Amended: Filed May 1, 2000, effective Oct. 30, 2000. Amended: Filed Sept. 27, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED AMENDMENT

12 CSR 10-24.190 Drivers License Retesting Requirements After a License, School Bus Permit or Temporary Instruction Permit Expires. The director proposes to add a section (3) and amend and renumber section (3) as section (4).

PURPOSE: This amendment is necessary due to the passage of Senate Bill 406, 91st General Assembly and clarifies that an individual may surrender a license from another state up to one hundred eighty-four (184) days after the expiration date and not be required to take the Class F examination.

(3) If a person is surrendering a license from another state, such person shall be allowed to surrender the license and obtain a Missouri license without being required to take the written and/or skills examinations as described in 12 CSR 10-24.060 provided the surrendered license has not been expired for more than six (6) months (one hundred eighty-four (184) days). This does not entitle the driver to continue to operate a motor vehicle while driving on an expired license.

[(3)] **(4)** If the end of the *[grace]* **one hundred eighty-four (184) day** period falls on a legal holiday, Saturday or Sunday, the one

hundred eighty-fourth day shall be deemed to fall on the next working day.

*AUTHORITY: section 302.173, RSMo [Supp. 1999] **Supp. 2001**. Original rule filed Oct. 30, 1989, effective Feb. 25, 1990. Amended: Filed July 15, 1991, effective Oct. 31, 1991. Amended: Filed Nov. 21, 1991, effective April 9, 1992. Amended: Filed June 29, 2000, effective Dec. 30, 2000. Amended: Filed Sept. 27, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED AMENDMENT

12 CSR 10-24.300 Commercial Drivers License Written Examinations. The director proposes to amend subsections (1)(F), (1)(G), delete subsection (1)(H) and amend sections (2), (3) and (4).

PURPOSE: This amendment is necessary due to the passage of Senate Bill 406, 91st General Assembly that no longer requires the written Class F examination when surrendering a license from another state.

(1) The following shall be the types of written examinations for Class A, Class B and Class C licenses:

(F) Passenger Vehicle Test—this examination shall consist of twenty (20) questions which shall include, but not be limited to, questions concerning loading and unloading procedures, proper use of emergency exits, proper responses to emergency situations, proper procedures at railroad crossings and drawbridges and proper braking procedures; **and**

(G) Double/Triple Trailer Test—this examination shall consist of twenty (20) questions which shall include, but not be limited to, questions concerning procedures for assembly and hookup of units, proper placement of heaviest trailer, handling and stability characteristics of double/triple combinations and potential traffic problems of double/triple combinations*[; and]*.

[(H) Class F Written Test—this examination shall consist of twenty-five (25) questions which shall include, but not be limited to, questions concerning an understanding of highway signs, proper turning, backing and signaling, and practical knowledge of the laws of this state. The Class F test will only be required when an applicant for a Missouri commercial drivers license surrenders an out-of-state commercial drivers license or commercial driver instruction permit, or the applicant has not been licensed in Missouri.]

(2) In order to obtain a Class A license, an applicant must take and successfully complete the Basic Knowledge Test, the Combination Vehicle Test*[,]* and *[if appropriate,]* the Air Brakes Test *[and/or the Class F Written Test]***, if appropriate**. The holder of an out-of-state commercial drivers license or commercial driver instruction permit can surrender his/her valid out-of-state license or permit and qualify for a waiver of the Class A Written Tests.

(3) In order to obtain a Class B license, an applicant must take and successfully complete the Basic Knowledge Test*[,]* and *[if appropriate,]* the Air Brakes Test *[and/or the Class F Written Test]***, if appropriate**. The holder of an out-of-state commercial drivers license or commercial driver instruction permit can surrender his/her valid out-of-state license or permit and qualify for a waiver of the Class B Written Tests.

(4) In order to obtain a Class C license, an applicant must take and successfully complete the Basic Knowledge Test*[, the Class F Written Test, if appropriate,]* and either the Passenger Test, the Hazardous Materials Test, or both. The holder of an out-of-state commercial drivers license or commercial driver instruction permit can surrender his/her valid out-of-state license or permit and qualify for a waiver of the Class C Written Tests.

*AUTHORITY: sections 302.735, RSMo [1994] **Supp. 2001** and 302.765, RSMo [Supp. 1997] **2000**. Original rule filed March 5, 1990, effective June 11, 1990. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Sept. 27, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED RULE

12 CSR 10-24.326 Third Party Tester and Examiner Sanction and Hearing Guidelines

PURPOSE: This rule establishes the guidelines for sanctioning third party testers and examiners for not conforming to the requirements of the third party tester contract, the laws and regulations of this state concerning commercial drivers and the provisions of the third party tester/examiner requirements produced by the Department of Revenue. It also includes the hearing rights and procedures of such parties.

(1) As used in this rule the following terms mean:

(A) Certification—the authority issued by the director of revenue to a third party tester to open a testing facility or to a third party examiner to administer testing for a third party tester;

(B) Decertification—the director of revenue's removal of authority or certification from a third party tester or examiner. Such removal shall be for a minimum period of one (1) year after which time a new application may be made; and

(C) Denial—the director does not issue a certification to a third party tester or examiner. Such tester or examiner once denied may

not reapply for a period of one (1) year.

(2) The department may warn, deny, refuse to issue or renew, suspend, revoke or decertify a third party tester or examiner's authority, whether initial or renewed. Such action may result from any violation of the third party tester contract or third party tester/examiner requirements, including but not limited to, those violations listed in the Missouri Department of Revenue Third Party Testing Program Sanctions for Examiner or Tester included herein and made a part of this rule. The department recommendations for sanctions are listed in the Department's Third Party Testing Program Sanctions for Examiners and Testers in this rule.

(3) The department shall notify the tester or examiner of its proposed action to deny, refuse to issue or renew, suspend, revoke or decertify a third party tester or examiner certification by mailing via certified mail, notice to the party's last known address in the department's records.

(4) The department's notice of proposed action shall state that the party may request a hearing on the denial, refusal to issue or renew, suspension, revocation or decertification by the department within thirty (30) days of the mailing of such notice.

(5) Failure to request a hearing shall result in the proposed action of the director becoming effective thirty (30) days from the date of mailing of notice.

(6) Upon receipt of a written request for a hearing, the director shall set a hearing date, a time and location designated by the director. Notice of hearing shall be mailed to the tester or examiner at the last known address for such entity within the department's records. Notice shall be complete upon mailing and shall state the time, date and place of hearing and the reason or reasons for the proposed action. If a hearing is requested, the action of the director shall be stayed until a hearing is held and an order entered thereon.

(7) Such hearings shall be conducted by the director or the director's designated hearing officer. Such hearings shall be heard in substantially the same manner as provided in Chapter 536, RSMo.

(8) The director shall enter a written hearing decision and mail that decision to the party requesting the hearing at the last known address for such party in the department's records.

(9) Further review of the action of the director as a result of an administrative hearing may be taken pursuant to section 302.311, RSMo.

(10) Nothwithstanding the provisions of section (5) of this rule the department may summarily revoke or suspend the certificate of a third party tester, without opportunity for stay, provided that the department finds that the public safety requires emergency action and it incorporates its findings to that effect in its notice of suspension or revocation. If so requested, a hearing to review the summary action and the underlying cause shall be held in an expedited time frame not to exceed thirty (30) days and the summary suspension or revocation shall be promptly determined.

(11) Any Missouri public school district and their pupil transportation contractor or Missouri state operated training center is exempt from the requirement and sanctions in the third party tester/examiner requirements stating the third party tester may not both train and test.

MISSOURI DEPARTMENT OF REVENUE THIRD PARTY TESTING PROGRAM SANCTIONS

EXAMINER

VIOLATIONS	FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE	FOURTH OFFENSE
EXAMINER RECORDKEEPING AND BUSINESS PRACTICES				
Examiner conducts test while non-certified, suspended or decertified.	Decertification			
Examiner conducts tests without DOR approval or conducts tests for more than one tester.	Decertification			
Examiner does not adhere to fee schedule.	Warning letter	30-day suspension.	60-day suspension.	Decertification
Examiner fails to maintain or complete records as required.	Warning letter	30-day suspension.	60-day suspension.	Decertification
Examiner fails to respond to DOR/MSHP request for information or fails to comply with DOR/MSHP instruction, directive or ruling.	Suspension until complies	Decertification		
EXAMINER QUALIFICATIONS				
Examiner application indicates felony conviction in last five years.	Denial/Decertification			
Examiner driving history indicates conviction for any alcohol related enforcement contacts (DWI, DUI, BAC, DUID, etc) in MO or any other state within lasts five years.	Denial/Decertification			
Examiner driving history indicates a suspension, revocation, cancellation or disqualification in MO or any other state within last five years.	Denial/Decertification			
Examiner fails to attend required re-certification courses as required by the Director every three (3) years or when required based upon audit findings.	Suspension until re-certification course completed.	Decertification		
Examiner fails to report suspension, revocation, cancellation or disqualification.	Suspension up to one year or decertification.			

SKILLS TEST ADMINISTRATION				
Examiner encourages or accepts bribe or gratuity.	Decertification			
Examiner falsifies records or information or misrepresents by omitting any test requirement or procedure.	Suspension up to one year and/or decertification.			
Examiner fails to inform DOR/MSHP concerning civil or criminal actions related to skills test.	Suspension up to one year and/or decertification.			
Examiner administers skills test without proper CDL License and appropriate endorsements and/or restrictions.	30-day minimum suspension and re-audit.	Decertification		
Examiner tests applicant for whom the tester/ examiner provided training. *** See Administrative Rule, Part 10, for exemptions to this policy.	30 day suspension	60 day suspension	Decertification	
Examiner knowingly re-tests failed applicant within same day.	Warning	30-day suspension	60-day suspension	Decertification
Examiner allows unauthorized passengers in the test vehicle during skills testing.	Warning and possible re-audit	30-day suspension	60-day suspension.	Decertification
Audit of examiner finds scoring and form completions inconsistent with TPT manual guidelines.	Re-audit and/or 30 day suspension	60 day suspension	Decertification	

MISSOURI DEPARTMENT OF REVENUE THIRD PARTY TESTING PROGRAM
SANCTIONS
TESTER

VIOLATIONS	FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE	FOURTH OFFENSE
TESTER RECORDS AND BUSINESS PRACTICES				
Tester operates without Department of Revenue authorization.	Application denied for minimum of five (5) years.			
Tester does not maintain insurance as required per section C –3 in tester contract.	Suspended until Department receives proof of required insurance.	30 day suspension and must submit proof of required insurance to Department of Revenue.	Decertification	
Tester does not maintain certificate of authorization for use of test site(s) as required.	Suspended until receipt of authorization and posting of certificate.	30 day suspension and must receive authorization and post certificate	Decertification	
Tester uses non-certified, suspended or decertified examiner.	Decertification			
Tester uses examiner without Department of Revenue approval or allows examiner to test for more than one tester.	Decertification			
Tester does not adhere to fee scheduling.	Warning letter to TPT	30 day suspension	60 day suspension	Decertification
Tester representative fails to attend audit/inspection without notification.	30-day suspension	60-day suspension	Decertification	
Tester fails to comply with monthly reporting requirements.	Warning letter to TPT	30 day suspension	60 day suspension	Decertification
Tester fails to respond to DOR/MSHP request for information or fails to comply with DOR/MSHP instruction, directive or ruling.	Suspension until complies	Decertification		
Tester fails to maintain permanent structure and business street address.	Suspension until complies	Decertification		
Tester records not maintained at each test site in centralized location.	If audit can be completed, warning letter to TPT. If audit cannot be completed, warning letter to TPT and reschedule audit.	30-day suspension.	Indefinite suspension until complies	Decertification
Tester fails to notify DOR of any changes to tester or examiner status.	Warning	30-day suspension.	Decertification	

TEST SITE FACILITIES				
Site does not comply with basic control, pre-trip and skills course layout or space requirements.	Warning and/or up to 30 day suspension	Warning and/or up to 60 day suspension	One (1) year suspension or possible decertification.	Decertification
TEST ADMINISTRATION				
Tester encourages or accepts bribe or gratuity.	Decertification			
Tester falsifies records or information, or misrepresents by omitting, any test requirement or procedure or encourages/requires examiner to do the same.	Decertification			
Tester fails to inform DOR/MSHP concerning civil or criminal actions related to complaints regarding skills testing.	Suspension up to one year pending additional action or decertification.			
Tester allows examiner to administer skills test without proper CDL license and appropriate restrictions or endorsements.	30-day suspension and re-audit.	Decertification		
Tester allows examiner to administer tests during non-daylight hours.	30 day suspension	60 day suspension	Decertification	
Tester allows examiner to knowingly re-test failed applicant within same day.	Warning	30 day suspension	60 day suspension	Decertification
Tester allows examiner to administer skills tests with unauthorized passengers in test vehicle.	Warning	30 day suspension	60 day suspension	Decertification
Tester administers test to employees or students whom the tester has trained. *** See Administrative Rule, Part 10, for exemptions to this policy.	30 day suspension	60 day suspension	Decertification	

AUTHORITY: sections 302.720 and 302.765, RSMo 2000. Original rule filed Sept. 27, 2001.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED AMENDMENT

12 CSR 10-24.402 Department of Revenue Instruction Permits. The director proposes to amend section (2) and delete the Missouri Drivers License or Identification Data Card form that follows this rule in the *Code of State Regulations*.

PURPOSE: This rule is being amended to add driver training instructors certified by the Department of Elementary and Secondary Education or qualified instructor of a private drivers' education program as required by section 302.130 and 302.178, RSMo.

(2) Until his/her sixteenth birthday, the holder of a temporary permit shall be accompanied at all times while driving a motor vehicle by a grandparent, parent**,** *[or]* guardian**, driver training instructor certified by the Department of Elementary and Secondary Education or a qualified instructor of a private drivers' education program** as defined in the following:

(B) Parent shall include a foster parent, stepparent or adoptive parent; *[and]*

(C) Guardian shall be a court-appointed guardian, or, in the event the parent, grandparent or guardian of the person under sixteen (16) years of age has a physical disability which prohibits or disqualifies them from being a qualified licensed operator, the parent, grandparent or guardian may designate a maximum of two (2) individuals authorized to accompany the applicant for the purpose of giving instruction in driving the motor vehicle. The designee must meet the requirements outlined in section 302.130, RSMo. The parent, grandparent or guardian must complete a certified statement prescribed by the director of revenue and must provide the designee's full name and driver*[']*s license number. The name and driver*[']*s license number of the designee shall be displayed on a label affixed to the temporary permit*[.]***;**

(D) A certified driver trainer must hold a valid drivers license and an education endorsement on a teaching certificate issued by the Department of Elementary and Secondary Education and may be a driver trainer employed by a federal residential job training program; and

(E) A qualified private drivers' education program instructor must hold a valid drivers license.

*AUTHORITY: sections 302.130**, RSMo Supp. 2001*** *and 302.132, RSMo [Supp. 1999] **2000**. Emergency rule filed Sept. 16, 1991, effective Sept. 26, 1991, expired Jan. 23, 1992. Original rule filed Sept. 16, 1991, effective Jan. 13, 1992. Amended: Filed Sept. 15, 1995, effective March 30, 1996. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Oct. 1, 1998, effective March 30, 1999. Amended: Filed Oct. 6, 2000, effective April 30, 2001. Amended: Filed Sept. 27, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED RULE

12 CSR 10-24.462 Prohibit Release of Information on Peace Officers and Their Immediate Family

PURPOSE: This rule defines the term "immediate family" and establishes the form used to request confidentiality of motor vehicle and driver record information pursuant to section 32.056, RSMo.

(1) Immediate family for purposes of this rule is defined as those who are related and living in the same household with the officer including, but not limited to, spouse, children or stepchildren.

(2) Requests for confidentiality of motor vehicle and driver record information must be made on an Application for Restriction of Information (Form DOR-4568) included herein.

MISSOURI DEPARTMENT OF REVENUE
DIVISION OF MOTOR VEHICLE AND DRIVERS LICENSING
RESTRICTION OF INFORMATION

FORM **4568** (REV. 8-01)

NAME LAST	FIRST	MIDDLE INITIAL	CLASSIFIED LICENSE NUMBER/SOCIAL SECURITY NUMBER	
STREET ADDRESS			DATE OF BIRTH	DAYTIME TELEPHONE NUMBER ( )
CITY	STATE	ZIP CODE	POSITION OR TITLE OR RELATIONSHIP TO OFFICER	
IF APPLICANT IS OTHER THAN OFFICER, PROVIDE OFFICER'S NAME				
PREVIOUS NAME				

MOTOR VEHICLE RECORDS

Please check this box if you are requesting restriction of information regarding your motor vehicle registration records.

☐ **PLEASE DO NOT RELEASE ANY INFORMATION ON MY VEHICLE REGISTRATION RECORDS.**

If you restrict your motor vehicle records, **NO ONE** will have access to your motor vehicle records including your insurance company or law enforcement. This may require you to provide additional proof of ownership or registration if you are stopped by law enforcement. Each time you title, register, or sell a vehicle, you must complete and submit this form and the appropriate application to the Driver and Vehicle Services Bureau, PO Box 100, Jefferson City MO 65105-0100, so your records can be updated accordingly. Telephone: (573) 751-4509, Fax: (573) 751-7060. You are not required to use this form when you renew your registration provided you use the confidential renewal notice the department issues to you. **To obtain a copy of your motor vehicle records, you must come to the Central Office, Harry S Truman State Office Building, Room 370, Jefferson City, MO.** Please list below information regarding vehicles registered in your name that you want restricted. (Attach additional sheet if necessary.)

	YEAR	MAKE	VEHICLE IDENTIFICATION NUMBER	CURRENT LICENSE PLATE NUMBER	EXP. YEAR
1.					
2.					
3.					
4.					

DRIVER LICENSE RECORDS

Please check this box if you are requesting restriction of information regarding your driver record for the first time. Request for restriction of information is only required one time for driver records. If you are only requesting restriction of driver record information, you must send this form to the Customer Assistance Bureau, PO Box 200, Jefferson City MO 65105-0200. Telephone: (573) 751-2730, Fax: (573) 522-8174. E-mail: dlbmail@mail.dor.state.mo.us

☐ **PLEASE DO NOT RELEASE ANY INFORMATION ON MY DRIVING RECORD.**

If you restrict your driving record, **NO ONE** will have access to your driver record including your insurance company or law enforcement. This may require you to provide additional proof of identification if you are stopped by law enforcement. **To obtain a copy of your driver record or image portfolio, you must come to the Central Office, Harry S Truman State Office Building, Room 225, Jefferson City, MO.**

I certify that I am a county, state or federal parole officer, federal pretrial officer or peace officer pursuant to section 590.100, RSMo, or member of their immediate family, and the facts provided herein are in conjunction with this application are true to the best of my knowledge. When I discontinue being a county, state or federal parole officer, federal pretrial officer or peace officer for any reason, I will notify the Department of Revenue.

☐ Check this box if you are notifying the Department of Revenue that you are no longer a county, state or federal parole officer, federal pretrial officer or peace officer pursuant to section 590.100, RSMo, or member of their immediate family, or if you no longer want your motor vehicle or driving record information restricted.

SIGNATURE	DATE	**KEEP A COPY OF THIS DOCUMENT FOR YOUR RECORDS**

FOR OFFICE USE ONLY

DVSB	ACTIVITY CODE	BATCH NUMBER	PROCESSED BY	DATE	If form indicates restriction of information requested for other bureau, forward a copy of this form to that bureau.
CAB	ACTIVITY CODE	BATCH NUMBER	PROCESSED BY	DATE	DATE FORM SENT TO OTHER BUREAU IF APPLICABLE

MO 860-2699 (8-01) DOR-4568 (8-01)

AUTHORITY: sections 32.056, RSMo Supp. 2001 and 590.100, RSMo 2000. Original rule filed Sept. 27, 2001.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more then five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Revenue, Office of Legislation and Regulations, PO Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

PROPOSED AMENDMENT

13 CSR 70-3.100 Filing of Claims, Medicaid Program. The division is amending sections (1), (2) and (5) and deleting the forms that follow the regulation in the *Code of State Regulations*.

PURPOSE: The proposed amendment updates which dental claim form and electronic claim format for pharmacy services must be used for filing claims to Missouri Medicaid, provides the Internet web site address for accessing Medicaid manuals, and incorporates specific claims filing instructions for payment in the regulation by reference to provider manuals.

(1) Claim forms used for filing Medicaid services as appropriate to the provider of services are—

(A) Nursing Home Claim—*[MO-8804, Revision 04/88]* **Fast Electronic Nursing Institution Xmission (FENIX), or individualized provider software when authorized by the state's fiscal agent**;

(B) Pharmacy Claim—MO-8803, Revision *[04/88]* **09/99 or POS, on-line claim format—NCPDP current version**;

(E) Dental Claim—*[MO-8802, Revision 04/88]* **ADA Dental Form**; or

(2) **Specific claims filing instructions are modified as necessary for efficient and effective administration of the program as required by federal or state law or regulation.** Reference the appropriate **Medicaid** provider manual and claim filing instructions for specific claim filing instructions information. **Medicaid Manuals, sample forms, and the Missouri Medicaid Forms Request document are available via the Internet at the Division of Medical Services web site—www.dss.state.mo.us/dms.**

(5) Denial. Claims that are not submitted in a timely manner **and** as described in sections (1) and (2) of this rule will be denied. Except that at any time in accordance with a court order, the agency may make payments to carry out hearing decision, corrective action or court order to others in the same situation as those directly affected by it. The agency may make payment at any time when a claim was denied due to state agency error or delay, as determined by the state agency.

AUTHORITY: sections 208.153 [RSMo Supp. 1991] and 208.201, RSMo [Supp. 1987] ***2000****. This rule was previously filed as 13 CSR 40-81.071. Original rule filed June 2, 1976, effective Oct. 11, 1976. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Sept. 28, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment is not expected to cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of the Director, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Office of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH *AND SENIOR SERVICES*
Division 10—Office of the Director
Chapter 5—Procedures for the Collection and Submission of Data to Monitor Health Maintenance Organizations

PROPOSED AMENDMENT

19 CSR 10-5.010 Monitoring Health Maintenance Organizations Definitions. The department proposes to amend this rule by amending the department Title, amending subsections (1)(A) and (B); amending subsections (2)(A), (C) and (D); amending subsection (3)(B); and replacing Tables A, B, and D.

PURPOSE: This amendment is to reflect the department name change by modifying section (1), subsections (A) and (B); to clarify the requirements on submission of annual member satisfaction survey data by modifying section (2), subsections (A), (C) and (D); to clarify the requirements on submission of audited quality indicator data by modifying section (3), subsection (B); to update Table A to reflect consistency with standards of the National Quality Assurance Committee; to update Table B to reflect the data specifications for the quality indicators; and to revise Table D to update and reduce required health care access information.

(1) The following definitions shall be used in the interpretation and enforcement of this rule:

(A) Department means Missouri Department of Health **and Senior Services**;

(B) Director means the director of the Missouri Department of Health **and Senior Services**;

(2) Starting in 1998, health care plans shall submit annually to the department, member satisfaction survey data—

(A) The member satisfaction survey shall be conducted according to HEDIS© technical specifications, including survey instrument, sample size, sampling method, *[and]* collection protocols **and CAHPS© component of the HEDIS© compliance audit**;

(C) In 1998 the data shall be submitted by September 1. In subsequent years a final member-level data file**, a summary level data file and a CAHPS© component audit verification letter** shall be submitted by June 15 or the date required by NCQA if other than June 15; and

(D) Medicare health care plans shall participate in a member satisfaction survey conducted by the *[Health Care Financing Administration]* **Centers for Medicare and Medicaid Services**.

The department will obtain the data from the *[Health Care Financing Administration]* **Centers for Medicare and Medicaid Services**.

(3) Starting in 1998, health care plans shall provide annually to the department, audited quality indicator data—

(B) All health care plans shall submit to the department documentation from a NCQA licensed organization that the quality indicator data submitted to the department have been audited through a partial or complete **compliance** audit according to HEDIS© specifications;

*AUTHORITY: section 192.068, RSMo [Supp. 1999] **2000**. Emergency rule filed Jan. 16, 1998, effective Jan. 26, 1998, terminated April 15, 1998. Original rule filed Jan. 16, 1998, effective August 30, 1998. Amended: Filed Oct. 30, 1998, effective May 30, 1999. Amended: Filed Dec. 20, 1999, effective May 30, 2000. Amended: Filed Sept. 15, 2000, effective April 30, 2001. Amended: Filed Oct. 2, 2001.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities sixty-three thousand dollars ($63,000) annually in the aggregate. See attached detailed fiscal note.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Health and Senior Services, Center for Health Information Management and Evaluation, Garland Land, Director, PO Box 570, Jefferson City, MO, 65102, (573) 751-6272. To be considered, comments must be received within (30) thirty days following the publication of this document in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: Department of Health and Senior Services

Division: Office of the Director

Chapter: Procedures for the Collection and Submission of Data to Monitor Health Maintenance Organizations

Type of Rule Making: Proposed Rule Amendment

Rule Number and Name: 19 CSR 10 - 5.010 Monitoring Health Maintenance Organizations

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities.
3	Health Plans and products	$63,000 annually

III. WORKSHEET

The estimate in the aggregate was calculated as follows. There are three (3) MC+ plan products in theWestern region that are independently affected by this rule during the reporting year 2002. The cost is estimated at $21,000 per product. The total annual cost to the health care plans is estimated at $63,000.

IV. ASSUMPTIONS

Costs to the MC+ health care plans that are affected by this rule change are estimated at $21,000 per product per plan per year. The number of affected products is calculated by determining the number of Medicaid health plan products that will be required to conduct independent, member satisfactions surveys for their enrollee populations, in accordance with the technical specifications in the rule. For the remaining plans, no new costs or additional costs are incurred. There are three (3) products that are independently affected by this rule. For these products the total cost to the health care plans, including external data collection expenses, is estimated at a $63,000 annually.

Table A

Member Satisfaction Survey Data File Specifications

File Content

Commercial: Member satisfaction survey data for commercial plans shall be based on the version of the NCQA-required Consumer Assessment of Health Plans Study (CAHPS) Questionnaire, applicable for the reporting year. The data reported to the Department shall include the member level and summary level satisfaction survey data from the commercial adult core set of questions, plus any NCQA-mandated or -recommended items for the adult segment of the questionnaire. The data shall also include any HEDIS measures specified in Table B, for a given product line and reporting year, that are collected via the CAHPS survey tool.

Medicaid: Member satisfaction survey data for MC+ plans shall be based on the version of the NCQA-required Consumer Assessment of Health Plans Study (CAHPS) Questionnaire, applicable for the reporting year. The data reported to the Department shall include the member level and summary level satisfaction survey data from the child survey (Medicaid version) plus any addtitional questions required by the Division of Medical Services for the reporting year. The data shall also include any HEDIS measures specified in Table B, for a given product line and reporting year, that are collected via the CAHPS survey tool.

File format and media

The member level and summary level satisfaction survey data and their respective record layouts shall be submitted electronically, using the data submission tools (DST) specified by the Department. Other file specifications shall conform to those required by NCQA for submission of the CAHPS Questionnaire results by the certified vendors.

File consistency

Plans that elect to submit separate files for sub-groups of their enrollment population must consistently do so for all data submission categories required by this rule.

Table B

Quality Indicator Data Specifications
Reporting Period: CY 2001

Data reported for each of the indicators listed below shall conform to the NCQA HEDIS Data Submission Tool and all other HEDIS technical specifications for indicator descriptions and calculations. An "X" in the table below indicates data are to be reported for this quality indicator if the health care plan offers this product line to Missouri residents.

	Applicable to:		
Indicator	**Commercial**	**Medicaid**	**Medicare**
Childhood Immunization Status	X	X	
Adolescent Well-Care Visits	X	X	
Use of Appropriate Medications for People with Asthma	X	X	
Chlamydia Screening for Women	X	X	
Breast Cancer Screening*	X		X
Cervical Cancer Screening*		X	
Beta Blocker Treatment After Heart Attack	X		X
Cholesterol Management After Acute Cardiovascular Event	X		X
Comprehensive Diabetes Care*	X		X
Antidepressant Medication Management	X		X
Flu Shots for Older Adults (CAHPS)			X
Annual Dental Visit		X	

*The plan may elect to use the prior year's data when the indicator is subject to rotation and is off-cycle for NCQA reporting.

File Content

As applicable for each of the quality indicators listed above, except for those collected via the CAHPS questionnaire, the plans shall report the following elements from the NCQA HEDIS Data Submission Tool:

1. Data collection methodology (Administrative or Hybrid.)
2. Eligible member population (i.e., members who meet all denominator criteria.)
3. Minimum required sample size (MRSS) or other sample size
4. Number of original sample records excluded because of valid data errors.
5. Number of records excluded because of contraindications identified through administrative data.
6. Number of records excluded because of contraindications identified through medical record review.
7. Additional records added from the auxiliary list.
8. Denominator
9. Numerator events by administrative data
10. Numerator events by medical record
11. Reported rate
12. Lower 95% confidence interval
13. Upper 95% confidence interval

All data elements above shall conform to the HEDIS technical specifications, as outlined in the NCQA-published technical manuals.

Table B

Quality Indicator Data Specifications
Reporting Period: CY 2001
(continued)

File format and media

The quality indicator data shall be submitted electronically, in a data file format to be specified by the Department. All other data specifications shall conform to those required by NCQA for submission of the audited quality indicator data.

File Consistency

Plans that elect to submit separate files for sub-groups of their enrollment population must consistently do so for all data submission categories required by this rule. Health care plans that contract with the Division of Medical Services to provide coverage in more than one Medicaid region, shall submit separate quality indicator data for the enrollees in each region.

Table D

Managed Health Care Services

File Specifications

Responses to the survey items in Table D must be submitted electronically, in a data file format specified by the Department.

Table D must be completed for each managed care product line (Commercial, Medicaid, or Medicare) offered by each licensed health care plan. Responses should be based on activity or status during the reporting period, within each product line (payer). Survey questions in Table D shall apply, except where otherwise noted, only to fully insured (ERISA exempt) enrollments.

Table D
Managed Health Care Services
Reporting Period: CY 2001

I. HEALTH PLAN INFORMATION

Instructions: Submit one set of Table D information, Parts I and II, for each product line (i.e. type of payor) offered by your organization.

1.) Product Line (CHECK ONE): ( ) Commercial ( ) Medicare ( ) Medicaid

2.) Missouri Department of Insurance Licensed Plan Name:

_____ Dba (if applicable): _____

3.) Extended NAIC Identification Number (7-digit): _ _ _ _ _ _ _

4.) Name as marketed to your members (for Consumer's Guide display purposes):

_____

5.) List the following for each of your products within this product line:

Marketed		----------Phone Numbers----------	
a.) Product Name	b.) HMO/POS	c.) Customer Service	d.) RN Hotline
_____	_____	_____	_____
_____	_____	_____	_____

6.) Through what organization was your managed care organization accredited as of : *December 31, 2001*?

Accrediting organization: ( ) NCQA ( ) URAC ( ) JCAHO ( ) None

Level of Accreditation: _____ _____ _____

7.) Managed Care Organization Contact Person for Table D Information:

a.) Name: _____ b.) Title: _____

c.) Phone: _____ d.) Fax: _____ e.) E-mail: _____

Table D
Managed Health Care Services
Reporting Period: CY 2001

II. HEALTH PLAN SERVICES

1.) Please indicate for each of the following high risk conditions/diseases, if your managed care plan (A) has screening mechanisms, (B) provides case management, (C) provides specific educational materials to persons-at-risk, and (D) distributes educational material for all plan enrollees. (CHECK ALL THAT APPLY. SEE NOTE BELOW.)

High Risk Conditions/Diseases	(A) Screening Mechanisms	(B) Case Management	(C) Education for Persons-at-risk	(D) Education for All Plan Enrollees
Asthma	( )	( )	( )	( )
Stroke/Cardiovascular Disease	( )	( )	( )	( )
Breast Cancer	( )	( )	( )	( )
Cervical Cancer	( )	( )	( )	( )
Ovarian Cancer	(NA)	( )	( )	( )
Colorectal Cancer	( )	( )	( )	( )
Congestive Heart Failure (CHF)	( )	( )	( )	( )
Chronic Obstructive Pulmonary Disease (COPD)	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )
Depression	( )	( )	( )	( )
HIV	( )	( )	( )	( )
Sickle Cell Disorders	( )	( )	( )	( )
High Risk Pregnancy	( )	( )	( )	( )
Obesity	( )	( )	( )	( )
Lead Poisoning	( )	( )	( )	( )
Chlamydia: Females	( )	( )	( )	( )
High Blood Pressure	( )	( )	( )	( )
Alcohol/Substance Abuse:				
Adolescents	( )	( )	( )	( )
Pregnant Women	( )	( )	( )	( )
Tobacco Use	( )	( )	( )	( )
Other _____ (PLEASE SPECIFY)	( )	( )	( )	( )

Note: Screening Mechanisms for a specific condition means 1) there is an established protocol for the plan's entire membership (health fairs or special events do not qualify under this criterion), 2) this protocol is available through the PCP's or personal physician's daily practice and 3) the screening is proactively targeted to persons at risk for the condition.

Case management is a protocol where case managers work with providers and physicians to coordinate the medical care that patients with complex or chronic illnesses need to receive. Case managers help patients take care of themselves and make sure they get the right specialists, equipment and medications.

Education strategies for all plan enrollees may include but are not limited to newsletters, periodicals, direct mailings and similar types of media campaigns.

2.) Please indicate if your managed care plan provides any of the following:

a.) Routine distribution of educational materials on general health promotion, disease prevention and wellness ( ) YES ( ) NO

b.) Distribution of pre- and post-surgical information to enrollees ( ) YES ( ) NO

Note: The term *reminder/recall* in Questions 3a – 3b refers to notices intended to insure timely scheduling of the specific preventive screening/test or service indicated. General education materials or notices tied to anniversary dates, such as birthdays or enrollment dates, do not meet this definition.

3a.) **Commercial or Medicaid only** (If completing for a Medicare plan, skip to Question 3b)

Do you send reminder/recall letters and/or make telephone calls from your managed care plan office to your members to ensure usage of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Pap smears	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

3b.) **Medicare only**

Do you send reminder/recall letters and/or make telephone calls from your managed care plan office to your members to ensure usage of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Well-woman checks	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

4.) **Commercial only:** During the reporting period, did your plan manage the following health services for your ASO group contracts? For each of the health services listed below, please indicate if it was elected as a covered benefit in all the ASO contracts with your plan, in some of the ASO contracts, or in none of the ASO contracts. (CHECK ONE COLUMN ONLY)

Selected Covered Benefits:	ASO Contracts		
	All Contracts	Some Contracts	None of the Contracts
Immunizations.....	( )	( )	( )
Mammograms	( )	( )	( )
Pap Smears.....	( )	( )	( )

5.) During the reporting period, did your plan provide coverage to your non-ASO members for the following health benefits? Please indicate if the benefit item was offered as standard coverage for <u>all</u> non-ASO products within the product line (commercial, Medicaid or Medicare), as standard coverage <u>only for some</u> non-ASO products in the product line, offered only by rider clause (employer option), or not covered at all. (CHECK ONLY ONE FOR EACH BENEFIT LISTED)

	Non-ASO Products Only			
	All Products	**Some Products**	**Offered only by rider clause**	**Not Offered**
Rx coverage of prenatal vitamins, including folic acid.....	( )	( )	( )	( )
Contraceptives:				
Birth control pills.....	( )	( )	( )	( )
IUDs.....	( )	( )	( )	( )
Norplant.....	( )	( )	( )	( )
Depo Provera.....	( )	( )	( )	( )
Immunizations:				
Hepatitis A.....	( )	( )	( )	( )
Hepatitis B.....	( )	( )	( )	( )
Annual eye exam for refractive errors.....	( )	( )	( )	( )
Diabetic supplies..... (strips, lancets, etc.)	( )	( )	( )	( )
Insulin pumps.....	( )	( )	( )	( )
Autologous bone marrow transplants.....	( )	( )	( )	( )
Stem cell rescue for breast cancer.....	( )	( )	( )	( )
Access to chiropractic services	( )	( )	( )	( )
Psychotherapy services				
Individual.....	( )	( )	( )	( )
Group.....	( )	( )	( )	( )
Family.....	( )	( )	( )	( )
Marital.....	( )	( )	( )	( )
Substance abuse services:				
Inpatient/residential.....	( )	( )	( )	( )
Outpt./partial hospitalization	( )	( )	( )	( )
Unrestricted annual flu shots	( )	( )	( )	( )
Smoking cessation classes <u>or</u> cessation medications..	( )	( )	( )	( )
Conduct wellness surveys*	( )	( )	( )	( )

*A wellness survey is a questionnaire on health behaviors. It does not refer to a physical exam.

6.) For each preventive service listed below, please indicate (A) if your plan provided physicians routine status reports on the delivery of these services to their panel members and (B) if your plan sent comparative information to the physicians, during the reporting year. Following each response, enter a brief description of the report(s) or information that you sent.

	(CHECK IF YES) (A) Plan Provided Reports	Description of Report(s)	(CHECK IF YES) (B) Plan Sent Comparative Data	Description of Report(s)
Childhood Immunizations	( )	_____	( )	_____
Adolescent Immunizations	( )	_____	( )	_____
Breast Cancer Screenings	( )	_____	( )	_____
Pap Smears	( )	_____	( )	_____
Chlamydia Screenings: Females	( )	_____	( )	_____
Lead Screenings:				
12 and 24 months	( )	_____	( )	_____
Under 6 if no prior blood test	( )	_____	( )	_____
Cholesterol Management after Acute Cardiovascular Event: LDL-C Screenings	( )	_____	( )	_____
Beta Blocker Treatment After Heart Attack	( )	_____	( )	_____
Comprehensive Diabetic Care:				
Hemoglobin Testing	( )	_____	( )	_____
Retinal Disease Eye Exam	( )	_____	( )	_____
LDL-C (Lipids) Testing	( )	_____	( )	_____
Nephropathy Screenings	( )	_____	( )	_____
Annual Flu Shots for Older Adults	( )	_____	( )	_____
Tobacco Cessation Counseling	( )	_____	( )	_____
Other (Please specify)_____	( )	_____	( )	_____

7.) Does your plan routinely conduct continuing education with your providers to improve their knowledge on current clinical practice recommendations?

( ) YES ( ) NO

8.) Please indicate the administrative policies for your HMO (non-POS) plan products, as they applied to your non-ASO members during the reporting year. (CHECK A RESPONSE FOR EACH POLICY LISTED)

	YES All HMO Products	YES Some HMO Products	NO No HMO Products
a.) Allow access to within-network OB/GYNs other than the once per year visit without referral	( )	( )	( )
b.) PCP must obtain prior authorization from HMO or its agency for referral to within-network, non-OB/GYN medical/surgical specialists	( )	( )	( )
c.) Allow members to self-refer to within-network medical/surgical specialists, other than OB/GYN	( )	( )	( )
d.) Allow members to self-refer to within-network mental health specialists	( )	( )	( )
e.) Allow medical specialists other than OB/GYN to be designated as PCP for patients with a chronic disease	( )	( )	( )
f.) Members can access some health practitioners, other than medical/surgical or mental health specialists, without referral or prior authorization	( )	( )	( )

g.) If YES for all or some products on Question 8f.), list the additional types of providers that can be accessed without referral or prior authorization:

All Products	Some Products
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9.) For each of the practitioner categories below, indicate the number you had in your plan network during the reporting year and the number of that total which your MCO verified, within the past two years, as being board certified where applicable.

	Number of Practitioners	**Number Who Are Board Certified**
a.) Primary Care Physicians (excluding OB/GYNs)	_____	_____
b.) Medical/Surgical Specialists (excluding OB/GYNs)	_____	_____
c.) OB/GYNs	_____	_____
d.) Chiropractors	_____	_____
e.) Mental Health Providers	_____	_____
f.) General Dentists	_____	_____
g.) Advanced Practice Nurse	_____	_____

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

PROPOSED RESCISSION

20 CSR 500-6.700 Premium Discounts for Using Managed Care Programs. Section 287.320, RSMo required workers' compensation insurance companies to extend a premium credit to any employer who contracted with a state-certified managed care organization. Pursuant to section 287.320, RSMo, this rule specified how such organizations were to be certified by the Department of Insurance, how large the premium credit was to be and when the insurance companies were required to extend the credit to employers. Section 287.320, RSMo was repealed in 1993 and replaced with a new provision, section 287.135, RSMo, the requirements of which differ in a number of respects from section 287.320, RSMo.

PURPOSE: The full text of this rule is being rescinded; it will be replaced with an entirely new rule. The Missouri Department of Insurance has decided that the changes necessary to amend the rule to conform to the requirements of section 287.135, RSMo were so numerous that it is more efficient to rescind the rule and replace it with a new rule than it is to amend the rule. A new "proposed rule" (set forth elsewhere in this ***Missouri Register****) has been filed along with this "proposed rescission" to act as the replacement for this rescinded rule.*

AUTHORITY: sections 287.320, RSMo Supp. 1992 and 374.045, RSMo 1986. Emergency rule filed Aug. 31, 1992, effective Nov. 1, 1992, expired Feb. 28, 1993. Original rule filed April 14, 1992, effective Feb. 26, 1993. Rescinded: Filed Oct. 10, 2001.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed rescission (and the accompanying proposed rule) on December 12, 2001, beginning at 10:30 a.m. in Room 492 of the Truman State Office Building in Jefferson City, Missouri. Opportunities to be heard at the hearing will be afforded to any interested person. Interested persons, whether or not heard, may submit written comments to the department until 5:00 p.m. on December 14, 2001. Written comments shall be sent to the Department of Insurance, Property and Casualty Section, PO Box 690, Jefferson City, MO 65102-0690, to the attention of Mark Doerner.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five (5) working days prior to the hearing.

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

PROPOSED RULE

20 CSR 500-6.700 Workers' Compensation Managed Care Organizations

PURPOSE: The proposed rule implements section 287.135, RSMo.

(1) Definitions.

(A) Access fee means the percentage of savings off the usual and customary charges for medical or rehabilitative services charged by an managed care organization (MCO) as reimbursement for access to its discounted provider network.

(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 licensed nurses experienced in the delivery of medical care under the workers' compensation system plan, 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 under section (15) of this regulation or re-certified under section (16) of this regulation.

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

(F) CPT-4 Code means a code contained in the *Current Procedural Terminology* published by the American Medical Association.

(G) Department means the Missouri Department of Insurance.

(H) 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.

(I) ICD-9 Code means any of the disease codes in the *International Classification of Diseases, Ninth Revision, Clinical Modification*, published by the United States Department of Health and Human Services.

(J) 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.

(K) 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 to manage the cost and utilization of care associated with claims covered by workers' compensation insurance. Unless the context clearly requires otherwise, when the term MCO is used in this regulation, it will mean an MCO certified under the provisions of this regulation.

(L) 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. 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 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, or some other form.

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

(N) 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 regulation.

(O) Pre-certification means the process of reviewing planned non-emergency medical care to assure said care conforms with an MCO's current managed care procedures.

(P) 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.

(Q) Qualified actuary means a fellow or member of the Casualty Actuarial Society.

(R) Supplemental MCO application forms means the form included in Exhibit B of this regulation or, in the alternative, any other form approved for use by the department which performs the same function.

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

(T) TPA means an administrator as defined under sections 376.1075 to 376.1095, RSMo.

(U) URAC means the Utilization Review Accreditation Commission.

(V) Utilization review (UR) 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 regulation, utilization review shall not include case management.

(W) Usual and Customary Fee Receipt, as required under subsection 3 of section 287.140, RSMo, means a charge by a health care provider for a treatment or service compensable under the workers' compensation law which is no greater than the fee received by the provider when the payor for such service is a private individual or a private health insurance carrier.

(2) Employers Shall State a Preference on Using an MCO.

(A) Under this regulation, an insured employer shall indicate whether or not he/she intends to use a workers' compensation MCO to manage the medical costs of work-related injuries and, if he/she does intend to use such an MCO, what MCO he/she would prefer. That preference will be set forth in writing on a Supplemental MCO Application Form as set forth at Exhibit B of this regulation, included herein, or an alternative form approved by the department. For newly issued policies, a Supplemental MCO Application Form shall be executed by the employer as part of his/her application for coverage and shall be submitted to the insurer along with the application. For any policy which is already in force on the effective date of this regulation and which covers a term of one (1) year, a Supplemental MCO Application Form shall be executed by the employer prior to any renewal of the policy. For any policy which is already in force on the effective date of this regulation and which covers a term of more than one (1) year, a Supplemental MCO Application Form shall be executed before the first annual anniversary date of the policy that occurs after the effective date of this regulation.

(B) The employer's specification of a preference as to the use of an MCO shall be deemed to be the employer's preference from the date the policy is issued and thereafter during all the subsequent uninterrupted renewals of that policy. An employer need not re-execute a Supplemental MCO Application Form for each renewal of a policy unless the employer would like to change his/her previously stated preference. Should an employer desire to change a previously stated preference mid-term, the employer should inform his/her agent who should in turn inform the insurer's MCO contact person, to determine whether the insurer is willing to continue coverage in concert with a new MCO.

(C) The insurer shall provide the insured or prospective insured a copy of the Supplemental MCO Application Form upon its completion by the employer. The insurer shall retain a copy of the completed Supplemental Application Form in its records, as part of the application, in accordance with regulation 20 CSR 300-2.200.

(3) Employer Options for Selecting an MCO.

(A) An employer may indicate his/her MCO preference by electing one (1) of the following options on a Supplemental MCO Application Form:

1. The employer may elect not to use any MCO;

2. The employer may elect to use only the MCO or MCOs with which the employer's insurer or prospective insurer has a contract under subsection (7)(E) of this regulation;

3. The employer may elect to use both the MCO or MCOs with which the employer's insurer or prospective insurer has a contract under subsection (7)(E) of this regulation and also a different MCO or MCOs of his/her own choosing. Regarding the MCO or MCOs of his/her own choosing, the employer shall also specify:

A. Whether the employer elects to have his/her insurer or prospective insurer pay any administrative fees of such an MCO; or

B. Whether the employer will pay any administrative fees of any such MCO himself/herself;

4. The employer may elect not to use any MCO with which the employer's insurer or prospective insurer has a contract under subsection (7)(E) of this regulation, but to instead use a different MCO or MCOs of his/her own choosing. Regarding the MCO or MCOs of his/her own choosing, the employer shall also specify:

A. Whether the employer elects to have his/her insurer or prospective insurer pay any administrative fees of such an MCO; or

B. Whether the employer will pay any administrative fees of such an MCO himself/herself.

(B) The department's web site shall contain information explaining the above options. Each Supplemental MCO Application Form shall contain a copy of the department's web site address from which this information can be obtained.

(4) Effect of Insurer Response to an Employer's Specification of a Preference for an MCO.

(A) If an employer has stated a preference for an MCO on a Supplemental MCO Application Form, which either has accompanied the employer's application for coverage or is submitted to the insurer prior to a renewal of coverage, and the insurer issues a policy to that employer or continues coverage, then the insurer shall be deemed to have acquiesced to the MCO option specified by the employer, as follows:

1. If the employer has specified that no MCO be used, then the insurer or prospective insurer will be deemed to have agreed to reimburse any health care providers selected by the employer at reimbursement levels authorized under section 287.140.3, RSMo;

2. If the employer has specified he/she will use any MCOs selected by his insurer or prospective insurer, then the insurer shall be deemed to have agreed to make such MCOs available for use by the employer and the employer's employees. The insurer shall coordinate and integrate its systems, reimburse MCO administrative fees and recognize health care provider discounts under terms agreed to in operating agreements between such MCOs and the insurer under subsection (7)(E) of this regulation;

3. If the employer has specified he/she will use both the MCO or MCOs selected by his/her insurer or prospective insurer and a different MCO or MCOs of his/her own choosing, then:

A. For those MCOs with which it has a contract under subsection (7)(E), the insurer or prospective insurer shall be deemed to have agreed to coordinate and integrate its systems, reimburse MCO administrative fees and recognize health care provider discounts under terms agreed to in operating agreements between such MCOs and the insurer under subsection (7)(E) of this regulation;

B. For those MCOs which the employer has himself/herself chosen and for which the employer has also elected to have the insurer to pay the MCO's administrative fees, the insurer or prospective insurer shall be deemed to have agreed:

(I) To coordinate and integrate its systems under section (7) of this regulation;

(II) To accept and process MCO administrative fee invoices under section (8) of this regulation;

(III) To recognize MCO discounts under section (9) of this regulation; and

(IV) To reimburse MCO administrative fees under sections (10) and (11) of this regulation; and

C. For those MCOs which the employer has himself/herself chosen and for which the employer has also agreed to pay the MCO's administrative fees himself/herself, the insurer or prospective insurer shall be deemed to have agreed:

(I) To coordinate and integrate its systems under section (7) of this regulation; and

(II) To recognize MCO discounts under section (9) of this regulation; and

4. If the employer has specified he/she will not use the MCO or MCOs selected by his/her insurer or prospective insurer and will instead use a different MCO or MCOs of his own choosing, then:

A. For those MCOs for which the employer has also elected to have the insurer pay the MCO's administrative fees, the insurer or prospective insurer shall be deemed to have agreed:

(I) To coordinate and integrate its systems under section (7) of this regulation;

(II) To accept and process MCO administrative fee invoices under section (8) of this regulation;

(III) To recognize MCO discounts under section (9) of this regulation; and

(IV) To reimburse MCO administrative fees under sections (10) and (11) of this regulation; and

B. For those MCOs which the employer has himself/herself chosen and for which the employer has also agreed to pay the MCO's administrative fees himself/herself, the insurer or prospective insurer shall be deemed to have agreed:

(I) To coordinate and integrate its systems under section (7) of this regulation; and

(II) To recognize MCO discounts under section (9) of this regulation.

(B) An insurer may also decline to issue a policy based on the employer's specification of an MCO. If an insurer has a written MCO policy, communicates that MCO policy to its agents, and adheres to that MCO policy, then that insurer shall not be considered to have engaged in any unfair discrimination if it treats otherwise similarly situated employers differently as to availability of coverage as a result of its adherence to that written MCO policy.

(C) If an insurer issues or renews a policy in acquiescence to the employer's selection of an MCO option, the insurer shall attach an endorsement to the policy reflecting that decision. The insurer shall also issue a new endorsement as necessary to reflect any change in the employer's selected MCO option that the insurer has agreed to under subsection (2)(B) above. Any endorsement form used under this subsection, whether it be a form developed by an individual insurer or a standardized form developed by a third party, shall be approved by the department prior to use.

(D) If an insurer has issued or renewed a policy for which the employer has specified an MCO which is not an MCO also under contract with the insurer, it shall be the responsibility of the insurer to notify the MCO of the insurer's acquiescence to the employer's preference. The insurer may satisfy this responsibility by providing the MCO with a copy of the Supplemental MCO Application Form as completed by the insurer or with a copy of the MCO endorsement added to the employer's policy.

(E) It shall also be the insurer's responsibility to notify the MCO if there is any change in the employer's coverage that effectively terminates his/her choice of MCO or the insurer's acquiescence to that choice. Any such notice shall be in writing.

(5) Disclosure by Insurers of their Policy on MCOs Prior to Application.

(A) An insurer shall develop a written policy on MCOs if it intends to exercise the option of declining coverage based on an employer's choice of MCO. Other insurers may develop such MCO policies if they see fit to do so. Any insurer that develops an MCO policy shall communicate this policy to its agents, who shall in turn communicate this policy to each employer before the Supplemental MCO Application Form is completed. In particular, an employer should be notified by an insurer or its agent whenever the MCO preference being contemplated by the employer could lead to a declination of coverage for that employer by the insurer.

(B) An employer shall be fully appraised of his/her MCO options and the insurer's likely reaction to the exercise of those options by the insurer or by the insurer's agent. The insurer should provide the employer with the insurer's written MCO policy if the insurer has developed such a policy and the employer should be told that more information on MCOs is available from the department at the addresses and contact numbers listed on the Supplemental MCO Application Form.

(C) If, during the policy term, the insurer changes its MCO policy in a fashion which brings it in conflict with the employer's stated MCO preference or has decided not to renew the employer's coverage due to the employer's MCO preference, the insurer shall communicate that fact to the insured in writing. The insurer shall accompany said notice with a copy of an amended written MCO policy developed by the insurer in accordance with section (6) of this regulation, and it shall provide the insured with a properly executed nonrenewal notice as required by law, if such nonrenewal is consistent with the insurer's MCO policy, provided that the insurer shall not be permitted to cancel policies mid-term due to a change in its MCO policy.

(6) Contents of Insurer MCO Policies.

(A) An insurer's MCO policy may include, but is not limited to, the following:

1. Whether the insurer will reimburse, coordinate with and integrate with employer-selected MCOs in general, or with specific MCOs in particular;

2. Whether the insurer will limit its interaction with MCOs to those MCOs with which the insurer has a contract under subsection (7)(E) of this regulation;

3. Whether there are any geographic limitations or geographic conditions on the insurer's MCO policy;

4. Whether the insurer's MCO policy is conditioned on any other factors, such as an employer's governing job classification, an employer's activities in other states or an employer's premium size;

5. Whether any debits or credits will be applied to the employer's insurance premium as the result of the MCO option ultimately selected; and

6. Any other factors the insurer considers relevant to the insurer's policy on MCOs.

(B) An insurer may modify its policy on MCOs from time to time. Each new version of the MCO policy will have a specified prospective effective date. A written copy of the insurer's past and present MCO policies shall be retained by the insurer's MCO contact person described in section (7) of this regulation.

(C) If an insurer develops a written MCO policy, communicates that MCO policy to its agents, and adheres to that MCO policy, then that insurer shall not be considered to have engaged in any unfair discrimination if it treats otherwise similarly situated employers differently as to the terms or availability of coverage as a result of adherence to that written plan.

(D) The department encourages each insurer to develop an MCO policy that allows employers the greatest freedom of choice of MCOs as is possible, consistent with the insurer's own organizational needs, structure and goals. In particular, the department encourages insurers to allow employers the flexibility to select an MCO in cases where the MCO with which the insurer has a contract under subsection (7)(E) does not serve the principle geographic areas wherein the employer conducts the majority of its business operations.

(E) Nothing in this section authorizes an insurer to require an insured employer to utilize the services of an MCO selected by the insurer as condition precedent to the payment by the insurer of individual claims required to be paid under Missouri law. The insured employer shall retain the 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. An employer may also voluntarily agree to use the providers in an MCO network selected by the insurer if the employer so chooses.

(F) It shall be permissible for an insurer to debit an employer's policy at audit for use of providers outside the MCO network specified by the employer so long as the insurer has previously communicated the possibility of such a debit to the employer via its written MCO policy.

(7) Coordination of Insurer and MCO Systems.

(A) An insurer that develops a written MCO policy shall file said policy, and any updates thereto, with the department. In addition to the written policy, the insurer shall designate an MCO contact person within its organization to whom inquiries about MCO-related issues can be directed from employers, employees, providers and MCOs. The insurer shall inform the department of this designation, and of any changes to this designation whenever they occur.

(B) Each workers' compensation MCO certified in Missouri shall designate an MCO contact person within its organization to whom inquiries about MCO-related issues can be directed from employers, employees, providers and insurers. The MCO shall inform the department of this designation, and of any changes to this designation whenever they occur.

(C) The department shall maintain a list of all insurer and MCO contact persons and shall make such information available upon request.

(D) Unless voluntarily agreed to otherwise by an insurer and an MCO, an insurer shall be required to coordinate and integrate its systems with those of an MCO only as follows:

1. It shall maintain a current listing of an MCO contact person with the department, as required under this section;

2. It shall inform prospective insureds and renewing insureds of its policy on MCOs, as required under section (2) above;

3. It shall accept MCO Administrative Fee Invoices under the default billing procedure as described in section (8) below if the insurer has agreed to pay the MCO's administrative fees by having issued an insurance policy to an employer who has specified a preference for such payment by the insurer;

4. It shall recognize MCO discounts under section (9) below;

5. It shall reimburse the MCO for its services to the extent required under the default reimbursement procedures as described in sections (10) and (11) below; and

6. It shall confer as necessary with the medical providers of the MCO to coordinate the treatment of the injured worker.

(E) In accordance with the provisions of subsection 3 of section 287.135, RSMo, an insurer and an MCO may enter into voluntary agreements which accomplish the purposes of reimbursing MCO administrative fees and coordinating and integrating the systems of the insurer and the MCO which differ from the requirements of this regulation relating to these matters. To the extent such voluntary agreements are in place, they supercede the provisions of this regulation relating to these matters, provided however, that the department may require the insurer or the MCO to produce such agreements for the purpose of the department's verification of their existence, extent and time period.

(8) Default Billing Procedure, MCO Administrative Fee Invoices, Alternatives.

(A) MCOs shall attach or include, at a minimum, as part of any bill to an insurer that has agreed under this regulation to reimburse the MCO for MCO administrative fees associated with work-related illnesses or injuries, an MCO Administrative Fee Invoice containing the following information:

1. MCO name;
2. MCO address;
3. MCO telephone number and facsimile number;
4. MCO billing contact person name;
5. Employer name;
6. Employer policy number;
7. Employer Federal Employer Identification Number (FEIN) number;
8. Injured employee name;
9. Employee Social Security Number (SSN);
10. Provider name;
11. Provider date-of-service; and
12. Documentation or explanation of MCO charges, which shall, at a minimum, include the following:

A. The date of service;
B. A description of the service;
C. The CPT or ICD-9 Code for the service;
D. The amount charged by the provider;
E. The amount allowed by the MCO (and, if appropriate whether this amount is based on a non-standard discount);
F. The saving realized by using the MCO network for that service;
G. The MCO's access fee;
H. The total MCO charges due (if more than one (1) service is listed);
I. An invoice date; and
J. An invoice number.

(B) An MCO shall submit its MCO Administrative Fee Invoice under subsection (8)(A) to insurers attached to a copy of the billing form from the medical provider which complies with the provisions of regulation 20 CSR 400-8.300, such as a UB-92 form or a HCFA 1500 form.

(C) MCO requests for reimbursement shall include both the MCO's administrative fees and, separately, the discounted charge for the provider's services. An insurer shall reimburse the two (2) charges separately.

(D) The insurer is not required to reimburse for MCO administrative fees if the insurer has not received a claim relating to injury or illness to which the services relate. In addition, an insurer is not required to accept MCO requests for reimbursement which are more than six (6) months after the date on which the services were rendered, unless the delay for the request for payment was not the fault of the MCO. MCO billing systems shall retain information on the date on which the original request for payment was made.

(E) MCOs are authorized and encouraged to list their requested reimbursement both as a dollar amount equal to a percentage of savings off the provider's billed charge, and as a percentage of savings that the discounted bill represents off the average, usual and customary fee of all providers for the service in question. When listing the savings off average, usual and customary fees, the MCO shall list the database relied upon to determine the usual and customary amount.

(F) Individual insurers and MCOs are authorized to enter into alternative billing arrangements under subsection 3 of section 287.135, RSMo. Any such alternative arrangements will take precedence over the provisions of this section.

(9) Insurer Responsibility for Recognizing MCO Discounts.

(A) An insurer shall recognize and honor the discounts on health care provider charges negotiated by the MCO as indicated on the MCO's Administrative Fee Invoice. However, if the insurer believes that the provider charge, even after the MCO's discount, is still in excess of what is allowed under section 287.140, subsection 3, RSMo, it may appeal the amount of the discounted health care provider charge under that subsection to the appropriate state agency.

(B) In cases where an employer's insurer reimburses a health care provider for the full amount of the provider's billed charges in violation of subsection (A) of this section, the employer may appeal any such overpayment to the department if that overpayment is used in the calculation of the employer's experience modification factor. The department shall direct the National Council on Compensation Insurance (NCCI) to correct the employer's experience modification factor if the evidence indicates that the bill was paid in full despite the fact that the insurer was obligated to recognize such discounts under this regulation.

(10) Default Reimbursement Procedure, Alternatives.

(A) For an insurer to be required under this regulation to reimburse an MCO administrative fee charged by an MCO, that fee must:

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, is fully certified under section (12) of this regulation;

6. Be from an MCO for which the employer has stated a preference on his/her application for insurance and which has coordinated and integrated its systems with those of the insurer under section (7) of this regulation;

7. Be the MCO's normal reimbursement fee; and

8. Be reasonable under section (11) below.

(B) If an MCO administrative fee meets the requirements of subsection (A) above, an insurer shall be obligated to pay the MCO fee stated on the MCO Administrative Fee Invoice, so long as the fee is the MCO's standard fee. That fee may be listed as a percentage of savings off billed charges or as a percentage of savings off usual and customary charges, or both, in accordance with subsection (8)(E) above.

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

(11) Dispute Mechanism over MCO Fees.

(A) Under subsection 3 of section 287.135, RSMo, MCO fees are required to be reasonable in relation both to the managed care services provided and to the savings that result from those services.

(B) If an insurer has issued a policy of workers' compensation insurance to an employer who has stated on the Supplemental MCO Application Form that the employer has a preference for a particular MCO and also that the employer elects to have the insurer reimburse the administrative fees of that MCO, then it shall be presumed that the insurer has agreed to reimburse any named MCO at the MCO's usual rate of reimbursement, and also that the MCO's rate of reimbursement is therefore reasonable under subsection (A) above.

(C) If an employer has elected on a Supplemental MCO Application form that he/she will use any MCOs under contract with the insurer and also another specified MCO or MCOs of his/her own choosing, whether a particular MCO of the multiple MCOs so selected is owed any administrative fee will depend in individual cases on whether or not the health care provider to whom the injured employee is referred is in the particular MCO's network and also whether the employer referred the employee to that provider after consulting the particular MCO. Where a health care provider is a member of both a network under contract with the employer's insurer and also a separate network selected by the employer, an insurer will be permitted to assume that the employee was referred to the provider after consulting with personnel of the insurer or the insurer's contract MCO, and therefore the insurer will be authorized to reimburse its contract MCO for its administrative fee in accordance with that contract. The insurer will not be obligated to pay the administrative fee of the separate MCO chosen by the employer unless it receives an MCO Administrative Fee Invoice attached to a bill from the health care provider who is in both networks. If the provider bill is initially received by the insurer without an MCO Administrative Fee Invoice and is later received a second time, attached to an MCO Administrative Fee Invoice, the insurer is nevertheless not required to honor that invoice if the provider bill has already been paid. In such a case, the only recourse for the separate MCO chosen by the employer is to take up the matter with the provider as a violation of the provider's contract with the MCO, a provision of which addresses this issue under paragraph (14)(A)7. of this regulation.

(D) If, in an individual case, the insurer disputes the amount of the underlying provider charge from which the MCO's fee is derived, the insurer may initially satisfy its obligation under this subsection by paying the MCO an administrative fee that is the equivalent to thirty-three and one-third percent (33 1/3%) of the difference between the average usual and customary fee for the medical procedure in question and the discounted provider charge indicated by the MCO on the MCO Administrative Fee Invoice. If this amount fails to satisfy the MCO, it may appeal the insurer's payment to the department. If the MCO can produce evidence to indicate the underlying provider charge is indeed the provider's usual and customary fee receipt as defined in section 287.140, subsection 3, RSMo the department may require the insurer to reimburse the MCO for any remaining unpaid portion of the MCO fee.

(12) Certification of MCOs.

(A) An MCO certified under this regulation is entitled to have its MCO administrative fees paid by an insurer to the extent such payment is required under this regulation.

(B) In order to be certified, an MCO must meet the following requirements except to the extent exempted under subsection (12)(C):

1. The MCO network requirements of section (13) of this regulation;

2. The MCO contract requirements of section (14) of this regulation; and

3. Comply with the certification procedures required under section (15).

(C) An MCO will be deemed to have met the network requirements of section (13) of this regulation to the extent it has met the URAC Utilization Review, Case Management and Network accreditation standards. Any MCO seeking an exemption under this provision shall nevertheless provide the department any materials necessary to document that accreditation or the particulars of the MCO's network.

(13) MCO Network Requirements. In order to be certified by the department and retain that certification, a workers' compensation MCO shall possess the following characteristics:

(A) A written organizational philosophy which has as a primary goal the use of appropriate procedures and incentives to medical providers to manage the cost and utilization of care associated with claims covered by workers' compensation insurance, and which is managed in Missouri and elsewhere by personnel with experience at successfully achieving this goal;

(B) A network of appropriately-licensed health care providers who have been selected and retained through a provider selection and peer review process as being willing and experienced at providing prompt medical care for work-related injuries and illnesses. The network shall, at a minimum, possess the following types of providers:

1. Medical doctors and surgeons;
2. Orthopedic surgeons;
3. Neurologists and neurosurgeons;
4. Physical and occupational therapists;
5. Psychologists and psychiatrists;
6. Diagnostic, laboratory and radiology services;
7. Hospital, outpatient and emergency care services; and
8. Plastic surgeons;

(C) A system of both appropriately-licensed and experienced personnel and facilities to provide, either in a hospital setting or through stand-alone centers, rehabilitation services as are appropriate to the individual injured employee. The MCO's rehabilitative services shall at a minimum include the following:

1. Comprehensive in-patient rehabilitation;
2. Chronic pain management programs;
3. Out-patient rehabilitation programs; and
4. Work-hardening programs;

(D) The ability to provide a system of appropriately-licensed and experienced personnel to provide the following types of ancillary managed care services in accordance with protocols established by the MCO, as modified by any particular agreements with individual employers or insurers. Unbundling of these services is permissible and may be necessary in order to coordinate and integrate the systems of the MCO with those of particular insurers:

1. Pre-certification and prospective utilization review by licensed registered nurses;
2. Concurrent utilization review by licensed registered nurses;
3. Telephonic case management by licensed registered nurses;
4. On-site case management by licensed registered nurses;
5. Retrospective utilization review by licensed registered nurses;
6. Provider bill auditing;
7. Hospital bill auditing;
8. Bill re-pricing;
9. Cost savings analysis;
10. Educational services for employers;
11. A continuing education program for network providers and other personnel; and
12. Data collection and reporting capabilities under section (17) of this regulation;

(E) A system of coordinating medical care, rehabilitation care and ancillary managed care services to manage the cost and utilization of care associated with claims covered by workers' compensation insurance while achieving prompt and appropriate maximum medical improvement and, where possible, prompt and appropriate return to work, under the direction of a medical director experienced with the Missouri workers' compensation system;

(F) Convenient access to the medical care and rehabilitative care services available through the MCO. Such convenient access shall include:

1. Telephonic access to the MCO for information and suggested referrals to area providers;
2. Twenty-four (24) hour emergency care;
3. Examinations and or evaluations within forty-eight (48) hours of request;
4. Other services accessible at reasonable times to all injured employees;
5. An adequate number of network providers for convenient access at any given location, with protocols for accessing non-network providers where necessary; and
6. MCO service areas which require an injured employee to cross no more than one (1) county boundary to receive treatment, except to the extent the MCO will absorb any travel expenses, or to the extent such travel is authorized by the insurer;

(G) A program to encourage network providers and other MCO medical personnel to receive continuing education annually on relevant topics related to occupational medicine, workers' compensation insurance, and the management of the care thereof, including such possible topics as:

1. Developments in occupational medicine;
2. Trends in the causes of work-related injuries or illnesses;
3. Techniques for avoiding common workplace hazards;
4. Options for return-to-work decision making;
5. Vocational rehabilitation;
6. Reporting requirements and other special provider requirements under the system;
7. Required treatment parameters;
8. Determining disability ratings;
9. Determining maximum medical improvement;
10. Permanent partial disability management;
11. Fraudulent claims;
12. Cases which have led to disputes;
13. Statutory, regulatory and case law developments; and
14. Developments in the managed care market;

(H) A billing procedure which conforms to the requirements of section (8) of this regulation;

(I) A system for analyzing the savings realized by employers utilizing an MCO, both in the aggregate and for specific employers;

(J) A data collection and reporting system which conforms to the requirements of section (17) of this regulation; and

(K) An internal dispute resolution procedure which informs participating employees of how, where and with whom to file a grievance and has grievances reviewed by someone within the organization of the MCO not involved in the underlying elements of the dispute, who promptly investigates the surrounding circumstances and provides a written explanation to the employee of the outcome of the investigation and recommendations for resolving the dispute, including notification of any right of appeal to the department or, where the issue relates to the appropriateness or necessity of medical treatment, to the Division of Workers' Compensation.

(14) MCO Contract Requirements.

(A) A department-certified MCO shall execute a written agreement with each participating health care provider setting forth the terms of the relationship between the MCO and the provider. In addition to any other provisions, such written agreements shall include the following provisions:

1. An agreement to maintain the confidentiality of information related to each injured employee;

2. An agreement by the provider to provide to the MCO any diagnosis, medical history, treatment plan, prognosis, return-to-work date or other medically- or rehabilitation-related information or documents requested by the MCO;

3. An agreement to adhere to the prohibition against billing the injured employee as set forth in section 287.140, subsection (13) RSMo;

4. An agreement by the provider to confer with the injured employee and with the MCO regarding the proposed course of treatment of the injured employee when requested;

5. An agreement by the provider to accept as reimbursement for medical services provided to an injured employee of an employer under contract with the MCO a fee based on a stated discount applied to the provider's usual and customary fee receipt for that service, or provisions which have this effect. Such agreement shall also provide for the re-pricing of a bill after the fact should the bill have been sent by mistake to the insurer instead of being sent to the MCO first, for re-pricing;

6. An agreement to request reimbursement for any medical services provided to an injured employee of an employer under contract with that MCO promptly enough so that the MCO can send the provider's bill and the MCO corresponding re-pricing sheet to the employer's insurer within sixty (60) days of the date the medical services were provided;

7. An agreement by the provider to send medical bills for those medical services provided to an injured employee of an employer under contract with that MCO and referred to the provider by that MCO, to that MCO so it may attach its MCO Administrative Fee Invoice to the bill, in compliance with the standardized billing requirements of section (8) of this regulation, rather than the provider sending the bill directly to the payor for payment; and

8. Such other conditions regarding the conditions, term and termination of the agreement as the parties deem appropriate.

(B) A certified MCO shall execute a written agreement with each participating employer setting forth the terms of the relationship between the MCO and the employer and the anticipated period of the agreement. In addition to any other provisions, such written agreements shall include the following provisions:

1. That the employer and the MCO have entered into an agreement under which the medical and rehabilitative treatments for injuries to the employer's employees compensable under the Missouri Workers' Compensation Law shall, at the employer's direction and control, in accordance with section 287.140, RSMo, be directed to the MCO for treatment;

2. That the employer and the MCO have selected a named contact person to be responsible for carrying out their respective responsibilities under the agreement. Should either the employer or the MCO change their designated contact person, they shall notify the other of the change as soon as is practical;

3. That either party may terminate the agreement upon written notice to the other;

4. That nothing in the agreement shall alter the employer's contractual duty under his/her workers' compensation insurance policy to notify his/her insurer of the occurrence of an injury;

5. The method and amounts for the MCO's services which shall be reimbursed by the employer, if any, the terms of the MCO's standard discounting arrangement with its providers and a fee disclosure list which lists any fees associated with the following activities and whether they will be charged to the employer or the employer's insurer:

A. Pre-certification;

B. Prospective utilization review;

C. Concurrent utilization review;

D. Telephonic case management;

E. On-site case management;

F. Retrospective utilization review;

G. Provider bill auditing;

H. Hospital bill auditing;

I. Bill re-pricing;

J. Cost savings analysis;

K. Educational services for employers;

L. Continuing education for network providers and other personnel; and

M. Data collection and reporting services; and

6. That an employer's insurer retains the right to review and contest the compensability, reasonableness or appropriateness of provider services.

(15) Certification Procedure.

(A) For purposes of obtaining the department's certification of an MCO, the organization shall provide the department with the following materials:

1. The MCO's, name, address, telephone, fax and e-mail addresses or numbers;

2. A general diagram of the MCO's organizational structure;

3. A listing of the MCO's officers, directors, managers and other personnel;

4. A thorough description of the MCO's experience with the management of health care costs associated with workers' compensation claims and with other health care claims, particularly of those persons who will be associated with the Missouri MCO's operations;

5. A description of how the quantity and quality of care will be managed by the MCO;

6. The MCO's most recently audited financial report;

7. The geographic area, by county, the MCO plans to serve;

8. A copy of the Missouri certifications for any UR firms which will be available for use by the MCO, if requested by the employer's insurer;

9. A copy of the current medical license of the MCO's medical director, as well as any relevant board certifications, such as a board certification for occupational medicine, as well as similar documentation for the Missouri-based assistant medical director, should the medical director not be a Missouri resident. Where one or both of the above parties lacks board-certification in occupational medicine, the MCO shall also provide a copy of that provider's curriculum vitae describing the provider's prior experience, including prior experience with the management of workers' compensation injuries and illnesses;

10. An explanation of the MCO's provider selection and written credentialing process;

11. A complete list of all primary care physicians, subspecialist physicians, rehabilitation centers, hospitals and work hardening centers to be employed by the organization, divided by county or city not within a county;

12. An explanation of the compensation arrangement(s) the MCO plans to use to fund its operations;

13. A description of any discounts applied to the usual and customary fee receipts of network providers, or categories of providers, negotiated by the MCO, as well as any other arrangements designed to manage the cost or use of care;

14. Copies of any MCO/provider and MCO/employer contracts to be used which shall include the required provisions set forth in section (14) of this regulation;

15. An analysis of the estimated savings to employers and insurers resulting from the use of the MCO. The analysis shall, at a minimum, include estimates of savings off billed charges, savings off usual and customary fee receipts, average cost per claim and average number of days lost due to illness or injury. The analysis shall be signed by a qualified actuary, who shall also include a brief description of his or her prior experience with workers' compensation insurance and with managed care organizations, as well as an explanation of the methodology by which the above estimates

were calculated. In providing this analysis, the actuary shall rely on the Actuarial Standards of Practice No. 8 and No. 16 adopted by the Actuarial Standards Board, in addition to any other relevant standards of practice. The actuary shall be prepared to discuss the methodology and conclusions of his/her analysis with personnel from the department, prior to certification;

16. The outline of the operation of the MCO to be provided to employers explaining their rights and responsibilities;

17. Copies of all marketing materials; and

18. Any other materials requested by the director.

(B) The materials required under subsection (15)(A) shall be collected in the order set forth above, in a main binder, separated by appropriately-labeled dividers, provided however, that any materials the MCO considers to be confidential in nature, such as MCO/provider reimbursement information, shall be placed in a supplementary binder, with appropriate cross references in the main binder where the confidential materials would otherwise have been placed. Confidential materials shall be handled by the department in accordance with the provisions of regulation 20 CSR 10-2.400, although any MCO which files materials labeled as confidential may be contacted by the department and discouraged from so filing.

(C) The materials specified in this section shall be retained by the department. Any significant changes to the nature of the 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, except for the MCO's list of providers for the department's web site, which shall be updated at least quarterly, and except for marketing materials, which shall be delivered to the department prior to their use.

(D) The department shall review these documents and grant certification, on the form contained in Exhibit A of this regulation, included herein, to those MCOs deemed to meet the criteria set forth in this regulation. Any departmental decision to deny certification shall be accompanied by a written explanation by the department of the reasons for denial.

(E) An MCO which is accredited under the National Workers' Compensation Standards of the American Accreditation HealthCare Commission/URAC shall be deemed to meet the standards of this section and section (13) regarding the adequacy of the MCO's network of providers. Such an MCO shall submit proof of its URAC accreditation to the department and shall provide any supplemental materials requested by the department, in addition to the other materials required under this section.

(F) The department shall designate the geographic extent to which a certified MCO's certification applies, for purposes of reimbursement under this regulation. As part of the certification process, the MCO shall provide the department with a series of maps indicating the location of its providers, as follows:

1. The department shall provide a map of the state of Missouri showing the names and boundaries of each county;

2. The MCO shall make duplicates of said map and shall label successive copies for "Primary Care Physicians," "Specialists," "Hospitals," and "Rehabilitation Centers";

3. The MCO shall, on the successive maps, place the number of providers of the type indicated on the label within the boundaries of each of the counties where said providers are located;

4. The department shall review the completed provider maps and grant a service area to the MCO which includes every county wherein all available types of providers are present in the network, as well as any counties bordering said counties; and

5. The MCO's service area shall be listed by county in the current list of certified MCOs, which is to be maintained by the department under section 287.135, RSMo, and provided to the Division of Workers' Compensation.

(16) Re-Certification Procedure.

(A) Any MCO which desires re-certification under this regulation shall submit the materials required under section (15) indicating any significant changes to its organization thirty (30) days prior to the anniversary date of its current certificate of authority. Each previously-certified MCO which is re-certified under this regulation, and each newly-certified MCO, shall thereafter annually file for re-certification at least thirty (30) days prior to the anniversary date of the certification granted under this regulation, to continue that certification.

(B) Upon initial certification and initial re-certification, an MCO shall pay a filing fee one thousand dollars ($1,000), made payable to "Missouri Department of Insurance." For annual re-certifications thereafter, the fee shall be one thousand dollars ($1,000). In addition to the fee, the MCO shall, in a cover letter, outline any significant changes made to any previous filing. The certification of each MCO previously certified that files for re-certification shall be extended until the evaluation of that filing is completed by the department.

(C) Any certified MCO shall cooperate with any reasonable on-site inspection of the MCO's facilities requested by the department.

(D) The department may, in writing, suspend or revoke the certification of an MCO at any time it establishes the criteria set forth in this regulation are no longer being met. The department may also suspend or revoke the certification of any MCO which has failed to honor its contractual responsibilities or which has engaged in any fraud or misrepresentation as part of its managed care activities. Any MCO so suspended or de-certified may request a hearing before the director or his/her designee concerning that suspension or de-certification.

(17) Data Reporting Requirements.

(A) The following data shall be reported by each department-certified MCO to the department for each calendar year beginning January 1, 2003 by July 1, 2004 and every calendar year thereafter:

1. The estimated aggregate number of participating employers during the reporting period;

2. The aggregate provider charges for treatment for participating employees;

3. The aggregate charges for treatment actually allowed by the MCO;

4. The discount on charges realized by the use of the MCO network;

5. The average cost per injury during the reporting period; and

6. Any other supplemental data the MCO determines would be useful in explaining the above.

(B) The MCO shall also report employer and employee names as required by the department in order to allow the department to conduct the satisfaction surveys authorized under section (18) of this regulation.

(C) The underlying data upon which the MCO bases the results to be reported under subsections (A) and (B) above shall be retained in the MCO's database or files for a period of at least one (1) year after the date of a report, for purposes of sampling verification by the department, should the department determine there is a need for such verification.

(D) Each MCO shall report said information in a computer format specified by the department.

(18) Quality of Care Survey.

(A) The department may, from time to time, conduct a satisfaction survey of employers and injured employees to assess the quality of care being provided by certified MCOs. Such a survey may be conducted at the discretion of the department but not more than once every two (2) years. No such survey need be conducted unless

the department determines that sufficient funds and personnel are available to conduct the survey.

(B) The department may conduct the survey of all employers with whom the MCO has contracts and all injured employees for which the MCO has managed the care, or any statistically appropriate subset thereof. MCOs shall provide the department with the relevant contact information for such employers and employees from its database, in the format requested by the department.

(C) The questions asked in the survey shall cover the matters deemed appropriate by the department. They may include but are not limited to the following:

1. The waiting time before an injured employee is seen by a physician;

2. The level of communication between the physician and the injured employee;

3. The services provided by the case management nurse, if any such nurse is assigned;

4. The level of apparent cooperation or conflict between the insurer, the MCO, and the health care providers;

5. The level of communication between the MCO and the employer regarding the status of the injured employee; and

6. Any suggested areas for improvement.

(D) Any individual survey responses from employers or injured employees shall be considered confidential communications under section 374.070, RSMo, and shall not be disclosed by the department. The department may however, in its discretion, summarize any survey results and make them available to the public.

(19) Procedure for MCO-Related Complaints.

(A) Any person who feels that the requirements of this regulation are not being adhered to by an MCO, an insurer or any other person may submit their concerns or complaints to the department for review. Formal written complaints shall be submitted on the standard department complaint form and shall be logged in the department's complaint database.

(B) The department shall review any formal complaint submitted. It may inquire into the surrounding circumstances and require additional information of the MCO, the insurer, the employer or other party as the situation warrants. If after review, the department determines that there is a violation of the regulation, it may impose such penalties or seek such remedial measures as it determines are warranted under the circumstances and as are permitted by law.

(20) Effective Date. This regulation shall become effective ninety (90) days after its publication in the Missouri *Code of State Regulations*.

Exhibit A **Certification Form**

Certificate of Authority
Managed Care Organization 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 for a period of one calendar year unless 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

Exhibit B **Supplemental MCO Application Form** **(Page One)**

Effective (MCO reg. effective date), Missouri employers will be required to state on this form whether or not they would prefer to use a workers' compensation managed care organization (MCO) to help control the medical costs associated with the work-related injuries of their employers.

Under Section 287.135 of the *Revised Statutes of Missouri*, the Department of Insurance has set certification standards for such MCOs. To be certified, an MCO must possess a geographically convenient network of primary health care physicians, specialists, hospitals and rehabilitation facilities under the medical direction of a physician experienced in Missouri's workers' compensation environment. In addition, the MCO must make available certain other, ancillary services, such as case management, utilization review, bill review and bill re-pricing, if agreed to by you, the employer, and the insurer.

The purpose of this form is to allow your current or prospective insurance company to know whether or not you have a preference for a particular MCO and if so, what that preference is. Making sure your insurance company understands your MCO preference is important because, by state regulation, if the insurance company issues or renews your policy after you have stated an MCO preference on this form, the insurance company is required to coordinate and integrate its systems with those of the MCO, and it may also be required to pay certain administrative fees of the MCO (unless you agree to pay these administrative fees yourself).

Different insurance companies have different corporate policies on interacting with outside MCOs. Some insurers will allow you considerable freedom in selecting an MCO, while other insurers have already contracted with specific MCOs to provide any needed managed care services. The latter group of insurance companies may decline to cover you if you specify an MCO on this form which differs from the MCOs they have under contract.

Therefore, it is important for you to know both the various MCO options that are available to you and also what impact the choice a particular MCO will have on your ability to obtain coverage. At a minimum, you should discuss this issue with the insurance agent prior to completing this form. In addition, if you have already developed a successful working relationship with a particular MCO, you should discuss the fact that you are considering switching carriers with your MCO before actually seeking out any new coverage. Finally, you may obtain more information about managed care and workers' compensation, the state's regulation of MCOs, a list of certified MCOs, and the potential costs and savings associated with the use of MCOs by telephoning the Missouri Department of Insurance at (800) 394-0964, or by accessing the Department's web site for its Frequently Asked Questions on Workers' Compensation MCOs brochure at www.insurance.state.mo.us/MCOfaqs.htm.

On page two of this form is a list of the various options available to you for completing this form. Select one of the numbered options. Once completed, the form will be submitted to the insurance company, which in turn will review it as part of the underwriting process. In addition, your insurance agent will give you a copy of the completed form for your records.

If the insurance company decides to issue or renew a policy for you under the MCO preference you have specified, it will attach an endorsement to your policy reflecting the selection you have indicated on this form. The insurance company will also notify any MCOs you have selected of its acquiescence to your selection.

Supplemental MCO Application Form **(Page Two)**

Select one (and only one) of the numbered "Options" listed below to specify your MCO preference; indicate your preference by placing your initials in the space provided next to the numbered option. For Options 3 and 4, you will also be asked to specify the name of one or more MCOs and to select one of two sub-options relating to who you prefer to pay for the MCO administrative fees related to the MCO(s) you have specified.

Option 1. _____ I elect not to use an MCO.

Option 2. _____ I elect to use only MCOs with which the workers' compensation insurer has a contract.

Option 3. _____ I elect to use both those MCOs with which the workers' compensation insurer has a contract and also the following MCO or MCOs:

_____
(Insert MCO Name)

_____
(Insert MCO Name)

For any MCO I have named above, I elect that:

_____ the insurer shall be responsible for the payment of the administrative fees of that MCO.

_____ I shall be responsible for the payment of the administrative fees of that MCO.

Option 4. _____ I elect not to use any MCOs with which the workers' compensation insurer has a contract, but instead to use the following MCO or MCOs:

_____
(Insert MCO Name)

_____
(Insert MCO Name)

For any MCO I have named above, I elect that:

_____ the insurer shall be responsible for the payment of the administrative fees of that MCO.

_____ I shall be responsible for the payment of the administrative fees of that MCO.

Applicant's Name and Title (Print or Type)	**Date**	**Applicant's Signature**

AUTHORITY: sections 287.135, 287.140, 374.045 and 374.070, RSMo 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. Rescinded and readopted: Filed Oct. 10, 2001.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate. See the attached fiscal note.

PRIVATE COST: This proposed rule will cost private entities more than five hundred dollars ($500) in the aggregate. See the attached fiscal note.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed rule (and the accompanying proposed rescission) on December 12, 2001, beginning at 10:30 a.m. in Room 492 of the Truman State Office Building in Jefferson City, Missouri. Opportunities to be heard at the hearing will be afforded to any interested person. Interested persons, whether or not heard, may submit written comments to the department until 5:00 p.m. on December 14, 2001. Written comments shall be sent to the Department of Insurance, Property and Casualty Section, PO Box 690, Jefferson City, MO 65102-0690, to the attention of Mark Doerner.
SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five (5) working days prior to the hearing.

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: Department of Insurance

Division: Property and Casualty

Chapter: Workers' Compensation and Employer's Liability

Type of Rulemaking: Proposed Rule

Rule Number and Name: 20 CSR 500-6.700 Workers' Compensation Managed Care Organizations

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Insurance	$12,939.80 in the first year, $4,377.80 annually thereafter.
(Optional Survey)	An additional $12,136.80 in the first year if a survey is conducted, an additional $7,124.00 every year thereafter in which a survey is conducted.
Division of Workers' Compensation	If the Department of Insurance does a Quality of Care Survey, it will consult with the Division of Workers' Compensation as part of developing the survey. It is estimated this will cost $5,000 in the first year such a survey is conducted, $1,000 in subsequent years.

(Note on cost for the second and subsequent years: This fiscal note estimates an annual impact for the first year and the subsequent years separately. More effort will be required in the first year to administer the re-certification procedure for existing MCOs and to file and maintain information on the MCO policies and MCO contact persons of insurers; in subsequent years, only amendments to these original materials will be necessary. The fiscal note estimates the cost for the second year of implementation; to calculate the impact for the third and succeeding years, the second year estimate should be multiplied by the appropriate inflation factor for the year in question.)

III. WORKSHEET

Department of Insurance:	Item		Annual Expense
First Year	Work Comp Specialists	276 hours @ $22.3/hour	$ 6,154.80
	Senior Counsel	214 hours @ $30.8/hour	$ 6,591.20
	Clerical	6 hours @ $14.9/hour	$ 89.40
	Consumer Services	4.5 hours @ $23.2/hour	$ 104.40
			$ 12,939.80

(Optional Survey)	Work Comp Specialists	168 hours @ $22.3/hour	$ 3,746.40
	Senior Counsel	168 hours @ $30.8/hour	$ 5,174.40
	Mailing Costs	...	$ 3,216.00
			$ 12,136.80
Subsequent Years	Work Comp Specialists	77.8 hours @ $22.3/hour	$ 1,734.94
	Senior Counsel	84.0 hours @ $30.8/hour	$ 2,587.20
	Clerical	1.4 hours @ $14.9/hour	$ 20.86
	Consumer Services	1.5 hours @ $23.2/hour	$ 34.80
			$ 4,377.80
(Optional Survey)	Work Comp Specialists	120 hours @ $22.3/hour	$ 2,676.00
	Senior Counsel	40 hours @ $30.8/hour	$ 1,232.00
	Mailing Costs	...	$ 3,216.00
			$ 7,124.00

Division of Workers' Compensation

IV. ASSUMPTIONS

Department of Insurance: The proposed regulation will increase the duties of the Department of Insurance in its oversight of managed care in the worker's compensation insurance market. These duties will be performed by existing Workers' Compensation Specialists, Senior Counsel, Information Systems, and Clerical personnel, using existing equipment. These new duties will include the following:

Total Yearly Hours: First Year/Second Year	**Additional Duties**
	Workers' Compensation Specialists
92 / 23	Track MCO certification anniversary dates to monitor annual renewal Review initial MCO re-certification materials for compliance with regulation Handle certification fees Make follow-up inquiries as necessary on certifications Recommend whether or not to certify MCO Maintain current MCO list for public on web-site
28 / 2.8	Create spreadsheet to track insurers MCO policies and their effective dates Receive written insurer MCO policies Enter data into spreadsheet File company MCO policies in company files Send duplicate "Filed" copy to carrier for its files Make information available to the public upon request
	Receive any MCO complaints from Consumer Services Respond to complaints or pass on to Senior Counsel as necessary
	Receive MCOs complaints on lack of full payment of MCO fee by insurer Review any documentation from MCO and health care provider Decide if enough evidence has been produced to establish that the provider fee

	charged is permissible under Section 287.140, subsection 3, and the case law
156 / 52	If the underlying provider fee is permissible, notify the insurer that it must reimburse the MCO at its full normal level of reimbursement If the underlying provider fee is not adequately supported by the evidence provided, disallow the MCO complaint Where necessary, discuss the matter with Senior Counsel
	Participate in survey development Receive employer/employee names from MCOs, follow-up with non-responders
168* / 120*	Type spreadsheet list of employers/employees to be surveyed Handle mailing of survey Receive and organize survey responses Follow-up with non-responders
	Senior Counsel
46 / 0	Check Specialist recommendations on MCO certifications/re-certifications Issue Certification Forms
	Handle any MCO complaints not handled by W/C Specialist
168 / 84	Review any MCO-related disputes and issue written response Provide written explanation for refusal to certify or for de-certification
	Develop satisfaction/effectiveness survey
168* / 40*	Tabulate survey results Write summary of survey Discuss survey results with MCOs
	Clerical
6 / 1.4	Enter TD2 Forms for insurer MCO Policy filings Update mail log regarding the above filings Send carriers monthly bills regarding the above filings
	Information Systems/Consumer Services
	Add codes to MIDS system to track any MCO-related complaints
4.5 / 1.5	Document any MCO-related complaints Process any MCO-related complaints
	Survey Costs
$ 3,216	Postage plus envelopes

* Denotes hours associated with optional survey.

The above estimates are based on the following assumptions:

(1) The new duties required under the regulation can be performed by existing personnel in the Department of Insurance with existing equipment. This is possible because the regulation will relieve the Department's staff of

current effort associated with handling questions and complaints on MCO issues without provisions or procedures to answer or resolve them. The above worksheet calculations used the current hourly level of reimbursement for the positions in question, which includes salary and fringe benefits (at 36.38% of salary).

(2) There are currently 23 Workers' Compensation MCOs certified by the Department. The Department assumes this number will remain the same, although it also assumes some will cease operations and others will enter the market for the first time. The fiscal note assumes it will take a Workers' Compensation Specialist four hours to review an MCO's certification packet for a total of (23 x 4) 92 hours, and two hours for the Specialist's recommendation to be reviewed by Senior Counsel who will either: a.) grant certification and issue a new certification form; or, b.) deny such certification and give a written explanation for that denial, for a total of (23 x 2) 46 hours. In the second and subsequent years, the Department assumes the Workers' Compensation Specialists will spend 30 minutes per MCO processing annual MCO updates and 30 minutes preparing and mailing annual renewal certificates.

(3) According to the National Council on Compensation Insurance (NCCI), there are 112 insurance companies currently writing workers' compensation insurance in Missouri. The Department assumes that each of these 112 insurers will file a written "MCO Policy" with the Department in the first year of the regulation. This fiscal note assumes that it will take a Workers' Compensation Specialist 15 minutes to document a policy's receipt in a spreadsheet, read the policy, place the policy in the insurance company's materials on file with the Department and return a duplicate copy of the policy stamped "Filed" to the insurance company. This will require ((112 x 15 minutes)/60 minutes) 28 hours of Workers' Compensation Specialist time in the first year. The Department assumes that in the second and subsequent years, insurers will file modifications to their plans at a rate of 10% the filings in the first year, for a total of 2.8 hours a year.

(4) The Department anticipates approximately one complaint a week regarding the proposed regulation, each of which will require on average, three hours of a Workers' Compensation Specialist's time to investigate, make a determination regarding, and respond to in the first year of the regulation, for a total of (52 weeks x 3 hours) 156 hour a year. In subsequent years the Department assumes the number of complaints will diminish to a third of this level. Those complaints that cannot be resolved by the Specialists will be referred to Senior Counsel, who it is assumed will spend approximately one working month in the first year attempting to resolve these complaints, and half a month per year in subsequent years.

(5) The proposed regulation gives the Department the option of doing a survey of employers to determine their level of satisfaction with the MCO services they have received. If it decides to exercise this option, the Department will require MCOs to provide a list of the employers and injured employees they have dealt with during the prior year. A sample of these employers and employees will be contacted by mail and asked to fill out a short questionnaire and return it, which the Department will collect, tabulate and summarize. The Department anticipates it will take the equivalent of one month for Senior Counsel to develop the survey and its procedures (with the assistance of the Division of Workers' Compensation), tabulate the results summarize them and discuss them with the MCOs, and another month for Workers' Compensation Specialists to collect MCO information, develop the list of employers and employees to be contacted, coordinate the mailing, collect the responses and follow-up with non-responders. The size of such a survey has yet to be determined, but according to the National Council on Compensation Insurance, Inc. (NCCI) there are 68,655 employers insured with workers' comp coverage in Missouri. Of those, the Department understands that approximately one quarter (17,164) use the services of MCOs; of these, roughly 20% (3,433) will experience injuries in a given year and would therefore be candidates for a survey. This fiscal note assumes all of these will be surveyed, although a smaller sample is also possible. In the second and subsequent years in which a survey is conducted, the Department assumes it will require 3 weeks of Workers' Compensation Specialist time and one week of Senior Counsel time to conduct such surveys. Each survey will require an envelope and postage, plus a return envelope and postage, (or 3,433 x 2 envelopes at $12.85 per hundred, or $882, plus 6,866 envelopes at $.34, or $2,334,) for a total of ($882 + $2,334) $3,216.

(6) Clerical work will include processing insurer filings and assisting MCOs and members of the public who wish to receive copies of materials filed with the Department. Because 112 insurer "MCO Policy" filings are anticipated in the first and because 30 transmittal documents (TD2 Forms) can be processed in an hour, it is estimated that it will take 3.7 hours to process these filings, plus additional time to learn the procedure, or 4 hours total, and a tenth of that in subsequent years. An additional 2 hours will be needed to maintain mail logs, send out monthly bills and assist the public in copying MCO-related materials in the first year, a one hour in subsequent years.

(7) A minimal amount (less than an hour) of Information Systems time will be needed to add Workers' Compensation MCOs to the Department's complaint database and train staff to recognize this new category. Additionally, Consumer Services staff will have to process any formal complaints and send them to the Department's Workers' Compensation Specialists, which should take approximately 5 minutes per complaint or ((52 complaints x 5 minutes)/60 minutes) 4.3 hours in the first year and ((17.3 complaints x 5 minutes)/60 minutes) 1.4 hours in subsequent years.

(8) Division of Workers' Compensation: The proposed regulation is not expected to increase the number of cases handled by the Division of Workers' Compensation regarding whether medical care services are "necessary and appropriate" (under Section 287.135.5, RSMo) or whether health care provider fees and charges are "fair and reasonable" and "usual and customary" (under Section 287.140.3, RSMo). The Division of Workers' Compensation currently handles roughly 2000 such matters a year with one FTE, most of which do not concern MCOs per se. To a significant degree, the regulation adopts the status quo that has evolved in the marketplace in the absence of a regulation regarding how MCOs are to be reimbursed by workers' compensation insurers. As such, the need to handle additional fee disputes is not anticipated.

(9) Should the Department of Insurance exercise the option under the regulation of conducting a survey of employers and employees to assess the level of satisfaction with managed care services, the Department anticipates it would consult with the Division regarding the mechanics of the survey, the questions in the survey and other related matters. The fiscal note anticipates that, in the aggregate, the personnel time the Division would have to devote in the development of a survey would be $5,000 in the first year and $1,000 for any years thereafter in which such a survey was conducted.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: Department of Insurance

Division: Property and Casualty

Chapter: Workers' Compensation and Employer's Liability

Type of Rulemaking: Proposed Rule

Rule Number and Name: 20 CSR 500-6.700 Workers' Compensation Managed Care Organizations

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by the type of the business entities which would likely be affected:	Estimate in the aggregate as to cost of compliance with the rule by the affected entities:
23	Department-Certified Workers' Compensation Managed Care Organizations (MCOs)	$46,000 ($2,000 per MCO) in the first year, $25,300 ($1,100 per MCO) annually thereafter.
112	Missouri-Licensed Workers' Compensation Insurers	$1,313,912 in the first year, $227,508 Annually thereafter.
68,655	Missouri Employers Insured by Workers' Compensation Insurance Polices	$731,584 in the first year, $150,316.80 in annually thereafter.

(Note on cost for the second and subsequent years: This fiscal note estimates an annual impact for the first year and the subsequent years separately. More effort will be required in the first year to administer the re-certification procedure for existing MCOs and to file and maintain information on the MCO policies and MCO contact persons of insurers; in subsequent years, only amendments to these original materials will be necessary. The fiscal note estimates the cost for the second year of implementation; to calculate the impact for the third and succeeding years, the second year estimate should be multiplied by the appropriate inflation factor for the year in question.)

III. WORKSHEET

MCO Costs

In the proposed regulation's first year, the currently certified MCOs will have to re-submit the materials required for certification. While these MCOs are "deemed" certified by Section 287.135, RSMo, the re-submission of this information will allow the Department to have a set of materials for all MCOs which are organized in a consistent format and which are up-to-date (which is currently not the case.) The Department estimates that it will cost these MCOs the equivalent of $1,000 each for the time and materials involved in this re-submission process. In subsequent years, the only materials which will be required to be filed will be those necessary to update these initial re-certification materials, which the Department estimates will require one-tenth the resources, or $100 per MCO.

In addition, the proposed regulation specifies a $1,000 certification fee for each MCO for the initial year and each subsequent year of the regulation.

Insurer Costs

According to the National Council on Compensation Insurance (NCCI), of the approximately 300 workers' compensation insurers that have written workers' compensation insurance in Missouri in recent years, only 112 are currently active (i.e., they have one or more policies in force). For purposes of this fiscal note, it is presumed that each active company will in fact develop a written corporate policy on MCOs, which it will file with the Department of Insurance in the first year of the regulation. Under Section 374.230, RSMo, the cost of each such filing is $50, for a total of $5,600 in filing costs. In subsequent years, the Department assumes that 10% of insurance companies will file modifications to their previously filed MCO policies each year, or $560.

It is presumed that each active insurer will require one man-week to define this corporate MCO policy, put that policy in writing and order the distribution of the MCO policy it to its agents. The Department estimates this man-week of effort to cost each active insurer $2,000, for a total of $224,000. The Department assumes that this process will need to be repeated in the second and subsequent years as insurance companies modify their MCO policies. The Department estimates this will happen at a rate of 10% of the first year's activity, costing (10% x $224,000) $22,400.

There are 34,799 licensed general casualty insurance agents in Missouri. The Department estimates that one third of them (11,600) are independent agents representing an average of 5 different companies. Of the remaining two-thirds (23,199), the Department assumes half (11,599) work for insurers that can notify them by e-mail of the new MCO policy. The other agents (both multi-company independent agents and single company captive agents) will need to be sent the new MCO policy by mail. The independent agents will need one notice from each of their 5 companies (11,600 x 5), or 58,000 letters. The captive agents will require 11,599 such letters. The total number of letter will be the sum of the two (58,000 + 11,599) or 69,599 letters. Assuming the MCO policy itself is only one page long, and assuming each such letter will also require a cover letter (2 pages x $.0045 per sheet of paper), an envelop (one envelop x $.1285) and postage (one stamp x $.34), or a total cost per letter of $.4775, then the total cost to inform the agent base by mail would be (69,599 x .4775) or $33,233. The Department estimates that such notification in the second and subsequent years will drop to 10% of the volume in the first year, since most carriers will establish their policy in the first year, and will only need to notify agents of modifications. The cost to the industry in the second and subsequent years is estimated to be (10% x $33,233) $3,323.

The NCCI's figures indicate that there are currently 68,655 outstanding policies of workers' compensation insurance for Missouri risks. Each policyholder will need to be informed of the insurer's new corporate MCO policy. The Department assumes this notice can be included in the mailing already done to renew the policy. Each such policy would also require a new Missouri MCO endorsement form. The Department estimates the cost of modifying the insurer's computer systems to generate such forms and include it as part of the policy materials sent to the employer

to be roughly one man-week's worth of programming time. Assuming a mid-level Information Systems employee receives a salary of $40,000 per year for a 50-week year, that would cost ($20 per hour x 40 hours) $800 per carrier. For the industry as a whole, with 112 carriers currently writing workers' compensation insurance in Missouri, the cost would be ($800 x 112) $89,600. The Department estimates the cost in subsequent years to be 10% of this amount, or $8,960. In addition, the cost of the extra endorsement pages would be (one page x $.0045 x 68,655) $309 in the first year, $31 dollars in subsequent years.

There will be additional costs to insurers to comply with the regulation. Insurance agents will in all likelihood have to discuss the Supplemental MCO Application Form and the employer's option with each employer before coverage is bound. In addition, an insurance company underwriter will need to review the Supplemental MCO Application form to confirm that it meets the carrier's MCO policy. The Department estimates that the cost of such steps will be approximately $10 per insured employer. While this cost will occur for each insured employer at least once, it will occur multiple times for employers who shop around for coverage. The Department assumes that of the total number of insured employers (68,655) 20% or (.20 x 68,655) 13,731 will consult two other insurers in addition to the carrier that finally issues the policy, or (68,655 + 13,731 x 2) 96,117 transactions requiring these additional MCO-related steps, for a cost of (96,117 x $10) $961,170. After the initial year, the cost to carriers will be less, because the regulation presumes the MCO policies of insurance companies and MCO choices of employers will remain the same, obviating the needed for repeated notices, discussions, supplemental application forms or endorsement forms. Only where the employer modifies its MCO preference, the insurer modifies its MCO policy or the employer finds new coverage will the process need to be repeated. The Department assumes these three scenarios will only occur 20% of the time, so the initial year's cost will be reduce to 20% of that cost in outlying years, or (20% x $961,170) $192,234 in the second and subsequent years.

Subtotal on Costs to Insurers:	**First Year**	**Second and Subsequent Years**
Filing Fees	$ 5,600	$ 560
Development of MCO Policy	$ 224,000	$ 22,400
Agent Notification	$ 33,233	$ 3,323
Information Systems Costs	$ 89,600	$ 8,960
Cost of Extra Endorsement Forms	$ 309	$ 31
Addition Explanations & Underwriting	$ 961,170	$ 192,234
Sub Total:	$1,313,912	$ 227,508

MCO Costs

In the proposed regulation's first year, the currently certified MCOs will have to re-submit the materials required for certification. While these MCOs are "deemed" certified by Section 287.135, RSMo, the re-submission of this information will allow the Department to have a set of materials for all MCOs which are organized in a consistent format and which are up-to-date (which is currently not the case.) The Department estimates that it will cost these MCOs the equivalent of $1,000 each for the time and materials involved in this re-submission process. In subsequent years, the only materials which will be required to be filed will be those necessary to update these initial re-certification materials, which the Department estimates will require one-tenth the resources, or $100 per MCO.

In addition, the proposed regulation specifies a $1,000 certification fee for each MCO for the initial year and each subsequent year of the regulation.

Employer Costs

The Department assumes that many employers will opt for the simplest alternatives and specify on the MCO Supplemental Application Form that they elect either to use no MCO or to use the insurance company's "contract" MCO. However, the Department assumes that at one third of insured employers (33.3% x 68,655) or 22,862 employers will give careful consideration to their choices and will shop around amongst an average of three carriers. The Department estimates this will require an average of 2 hours of time by the employer, from an employee with an average salary of $32,000 a year. Assuming a 50-week work-year, six hours of such a person's time would be worth ($16 per hour x 2 hours) $32, for a total of ($32 x 22,862) $731,584 of additional decision-making time and effort in the first year. In the second and subsequent years, the Department assumes that the majority of these employers will maintain the same arrangements, but that one-fifth will make some change each year, which will require additional effort to find alternative arrangements, at an estimated cost of (20% x $731,584) $150,316.80 a year.

[Note: Part of the above cost will be borne by small businesses (i.e., independently owned and operated entities with fifty or fewer full-time employees), although the Department presumes that most small businesses will opt to use an MCO selected by (and reimbursed by) their insurer. However, those small employers who have experience with workers' compensation claims or who have developed other workers' compensation experience may decide to shop around for the best MCO/Insurance Company combination for them, which will result in the additional search costs discussed above.]

Because the employer's MCO selection remains in force unless the insurer amends its MCO policy, or the employer changes his selection of an MCO or shops for new coverage, an employer does not need to consider his MCO selection once his original choice is made and agreed to by the carrier. Therefore, the Department estimates that the additional cost to employers in outlying years will be only 20% of the cost in the initial year.

IV. ASSUMPTIONS

MCO Costs

Rule 20 CSR 500-6.700 was originally promulgated in 1992 to implement a provision of Section 287.320 RSMo (since repealed) that authorized a premium credit to employers who selected a state-certified workers' compensation MCO. While the regulation required that insurers provide such a premium credit, it did not require the reimbursement of MCOs for their services. In 1993, the General Assembly repealed Section 287.320, RSMo and adopted what is currently Section 287.135, RSMo, which directed the Department of Insurance to promulgate a regulation on the payment of MCO fees. Because no regulation on MCO fees has been in place since 1992, MCOs have had to adapt, being paid only by those insurers who voluntarily agreed to such reimbursements or by insured and self-insured employers.

Because the proposed regulation relies on market forces and voluntary agreements between insurers, employers and MCOs regarding MCO reimbursement, the Department assumes there will be little change from the current reimbursement environment. The new costs to MCOs imposed by the regulation will be offset either by cost savings or by slightly higher utilization of MCOs.

Costs: The fiscal note above estimates certain costs of complying with this regulation. In addition, there may be other, less specific costs. For example, MCOs may decide that it makes sense to discuss the MCO concept with employers with whom they already have contracts and with new employers, reminding them of the MCO preference options they will be confronted with on policy acquisition or policy renewal. They may decide to track policy renewal dates in their computer systems to prompt these reminders.

Savings or Increased MCO Utilization: Because employers will be reminded of the MCO issue as part of the process of procuring new coverage, the regulation should reduce the number of instances where an MCO, confident of reimbursement because the employer's prior carrier had agreed to it, delivers service only to learn that the employer's new carrier will not agree. This will save MCOs from absorbing the cost of such services. In addition, the fact that every employer will not need to give at least passing consideration to the issue of workers' compensation MCOs during the process of applying for coverage, the use by average employers of MCOs should increase.

These potential costs, savings and increased utilization are difficult to estimate. However, the Department assumes the effects of these factors will cancel each other, resulting in no net impact in cost to the MCOs as a "category" of private entities.

Employer Costs

This fiscal note also does not estimate an impact on insured employers as to the savings they might realized by using MCOs. While the use of MCOs should help, in the aggregate, to reduce the medical losses and possibly the indemnity losses, the cost to employers of their workers' compensation insurance is determined by their insurers as part of the insurers' rate setting function, and it is up to insurers to decide whether and to what extent any savings realized will be passed on to employers. Those employers who choose to use an MCO which will not be reimbursed by their carrier will presumably have concluded that the net effect of having to pay these MCO fees themselves is more than offset by the savings realized by using that MCO.

Health Care Providers Costs

This fiscal note does not estimate an impact on health care providers of the proposed regulation, for two reasons: 1) Certified MCOs have been in operation under the prior version of the proposed regulation since November 1, 1992. There are currently 23 active certified MCOs in Missouri. The fiscal note assumes that any health care providers who desired to join an MCO would already have done so and are therefore currently providing services at the discounted rates which would merely be continued under the proposed regulation; and, 2) Nothing in the regulation limits health care provider reimbursements to amounts less than that allowed by Section 287.140.3, RSMo, without the provider's consent. Providers are free to charge their usual and customary fee unless they have voluntarily agreed to discount those fees under a contract with an MCO.