



---

---

**Rules of**  
**Department of Insurance,**  
**Financial Institutions and**  
**Professional Registration**  
**Division 100—Insurer Conduct**  
**Chapter 5—Health Care Consumer Procedures**

<b>Title</b>	<b>Page</b>
<b>20 CSR 100-5.010</b> Notice Requirements of an Adverse Determination.....	3
<b>20 CSR 100-5.020</b> Grievance Review Procedures .....	3



**Title 20—DEPARTMENT OF  
INSURANCE, FINANCIAL  
INSTITUTIONS AND  
PROFESSIONAL REGISTRATION  
Division 100—Insurer Conduct  
Chapter 5—Health Care Consumer  
Procedures**

**20 CSR 100-5.010 Notice Requirements of  
an Adverse Determination**

*PURPOSE: This rule sets forth with greater specificity the requirements of written notification when a health carrier informs an enrollee of a health plan that includes a managed care component of an adverse determination. This rule is promulgated pursuant to section 376.1399, RSMo, and implements section 376.1363.5, RSMo.*

(1) A written notification of an adverse determination shall be printed in clear legible type of at least twelve (12)-point font.

(2) The notice shall explain the principal reason for the adverse determination in language easily understood by a person with an eighth grade reading level. A health carrier may determine the reading level of a notice without including medical terminology which describes an enrollee's medical condition, proper names, telephone numbers and addresses.

(3) The notice shall explain how an enrollee initiates a grievance review. If an enrollee is eligible for an expedited review pursuant to section 376.1389, RSMo, then the notice shall explain how an enrollee initiates an expedited review.

(4) The notice shall explain how an enrollee as defined in section 376.1350(14), RSMo initiates a grievance review of the adverse determination with the director. The notice shall explain that an enrollee may file a grievance with the director at any time. The notice shall also list the Consumer Affairs Division's toll-free telephone number.

(5) The notice shall describe how the enrollee can request a written statement of the clinical rationale and clinical review criteria used to make the adverse determination.

(6) If the Health Care Financing Administration's Medicare or Medicaid plans have notification requirements for grievance procedures, those notification requirements shall satisfy the requirements of this rule for notification of enrollees in those plans if the

notices comply with all Missouri statutory requirements.

(7) The notice shall inform enrollees that they have a right to have a relative, friend, lawyer, the department or other representative help them with a grievance.

*AUTHORITY: sections 374.045 and 376.1363.5, RSMo 2000 and section 376.1399, RSMo Supp. 2007.\* Original rule filed Nov. 3, 1997, effective June 30, 1998. Amended: Filed Nov. 1, 2007, effective July 30, 2008.*

*\*Original authority: 374.045, RSMo 1967, amended 1993, 1995; 376.1363, RSMo 1997; and 376.1399, RSMo 1997, amended 1997, 2007.*

**20 CSR 100-5.020 Grievance Review  
Procedures**

*PURPOSE: This rule sets forth with greater specificity the procedures by which the department will process a grievance concerning an adverse determination by a health carrier or its designee for a health plan that has a managed care component. This rule is promulgated pursuant to section 376.1399, RSMo, and implements section 376.1387, RSMo.*

(1) As used in this rule, "division" means the Consumer Affairs Division.

(2) When a health carrier, as defined by section 376.1350(22), RSMo, or their designee utilization review organization issues an adverse determination, as defined by section 376.1350(1), RSMo, to an enrollee in a health plan that has a managed care component, the enrollee or his/her representative may file a grievance with the director without exhausting all remedies available under the carrier's grievance process. Medicaid participants also may use the division's grievance process in an effort to resolve an adverse determination; however, the director may not have the authority to issue an order in such cases.

(3) A health carrier or plan sponsor also may file a grievance with the director concerning an adverse determination.

(4) A grievance will be processed by the division as any other consumer complaint. The division will assign the grievance a file number. The division will send an inquiry to the health carrier (or party) which is complained against requesting the health carrier (or party) to respond in writing with their posi-

tion and all supporting documentation concerning the matter grieved. The division will attempt to resolve the issue with the health carrier (or party).

(5) If the director determines a grievance is unresolved after completion of the division's consumer complaint process, the director shall refer the unresolved grievance to an independent review organization (IRO). An unresolved grievance shall include a difference of opinion between a treating health care professional and the health carrier concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a health care service.

(6) The director will provide the IRO and upon request the enrollee, enrollee's representative or health carrier copies of all medical records and any other relevant documents which the division has received from any party. The enrollee, enrollee's representative and health carrier may review all the information submitted to the IRO for consideration.

(7) The enrollee, enrollee's representative or health carrier may also submit additional information to the division which the division shall forward to the IRO. All additional information must be received by the division. If an enrollee, enrollee's representative or health carrier has information which contradicts information already provided the IRO, they should provide it as additional information. All additional information should be received by the division within fifteen (15) working days from the date the division mailed that party copies of the information provided the IRO. An envelope's postmark shall determine the date of mailing. Information may be submitted to the division by means other than mail if it is in writing, typeset or easily transferred into typeset by the division's technology and a date of transmission is easily determined by the division. At the director's discretion, additional information which is received past the fifteen (15) working-day deadline may be submitted to the IRO.

(8) The IRO shall request from the division any additional information it wants. The division shall gather the requested information from an enrollee, enrollee's representative or health carrier or other appropriate entity and provide it to the IRO. If the division is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.



(9) Within twenty (20) calendar days of receiving all material, the IRO shall submit to the director its opinion of the issues reviewed. If the IRO requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review. Such a request should include the reasons for the request and a specific time at which the review is expected to be complete.

(10) After the director receives the IRO's opinion, the director shall issue a decision which shall be binding upon the enrollee and the health carrier.

*AUTHORITY: sections 374.045 and 376.1387, RSMo 2000 and section 376.1399, RSMo Supp. 2007.\* Original rule filed Nov. 3, 1997, effective June 30, 1998. Amended: Filed Nov. 1, 2007, effective July 30, 2008.*

*\*Original authority: 374.045, RSMo 1967, amended 1993, 1995; 376.1387, RSMo 1997; and 376.1399, RSMo 1997, amended 1997, 2007.*