Rules of
Department of Insurance, Financial Institutions and Professional Registration
Division 100—Insurer Conduct
Chapter 1—Improper or Unfair Claims Settlement Practices

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 100—Insurer Conduct

Chapter 1—Improper or Unfair Claims Settlement Practices

20 CSR 100-1.010 Definitions

PURPOSE: This rule sets forth definitions used in the rules in this division to aid in the interpretation of various terms and phrases.

(1) As used in the Unfair Claims Settlement Practices Act at sections 375.1000 to 375.1018, RSMo and in the regulations promulgated pursuant thereto—

(A) "Insurance producer" or "producer," any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

(B) "Claim,"—

1. A request or demand for payment of a loss which may be included within the terms of coverage of an insurance policy; or

2. A request or demand for any other payment under the policy, such as for the return of unearned premium or nonforfeiture benefits;

(C) "Claimant," any—

1. First-party claimant, including a subscriber under any plan providing health services;

2. Third-party claimant; or

3. Person or entity submitting a claim on behalf of any insured and includes the claimant's designated legal representative and a member of the claimant's immediate family designated by the claimant;

(D) "First-party claimant," any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of the occurrence of a contingency or loss covered by an insurance policy;

(E) "Insurer," any legal entity organized, incorporated or doing business under the provisions of Chapter(s) 354, 375–379, 381 or 383, RSMo or otherwise engaged in the business of insurance in this state;

(F) "Investigation," all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy;

(G) "Notification of claim," any notification, whether in writing or by other means acceptable under the terms of an insurance policy to an insurer or its insurance producer, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(H) "Third-party claimant," any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy;

(I) "Insurance policy," any insurance contract, certificate of insurance or contract under which health services are to be provided; and

(J) "Time error rate," refers to any one (1) of the following:

1. Acknowledgment time error rate, the percentage of claims in which the insurer has performed an act described in section 375.1007(2), RSMo, or violated 20 CSR 100-1.030;

2. Investigation time error rate, the percentage of claims in which the insurer has performed an act described in section 375.1007(3), RSMo, or violated 20 CSR 100-1.030; or

3. Determination time error rate, the percentage of claims in which the insurer has performed an act described in section 375.1007(7), RSMo, or violated 20 CSR 100-1.050.

AUTHORITY: section 374.045, RSMo 2000 and sections 375.1000–375.1018, RSMo 2000 and RSMo Supp. 2007. This rule was previously filed as 4 CSR 190-10.060(1). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Aug. 16, 1978, effective Dec. 11, 1978. Amended: Filed Sept. 11, 1980, effective Feb. 16, 1981. Amended: Filed Sept. 14, 1981, effective Jan. 15, 1982. Amended: Filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Jan. 5, 1987, effective June 1, 1987. Amended: Filed Aug. 4, 1987, effective Dec. 24, 1987. Amended: Filed Dec. 9, 1988, effective April 28, 1989. Amended: Filed Nov. 2, 1989, effective Feb. 15, 1990. Emergency amendment filed Feb. 21, 1990, effective March 5, 1990, expired June 2, 1990. Amended: Filed Feb. 26, 1990, effective June 11, 1990. Amended: Filed Dec. 12, 1990, effective June 10, 1991. Amended: Filed Oct. 1, 1996, effective June 30, 1997. Amended: Filed Dec. 1, 1998, effective July 30, 1999. Amended: Filed July 12, 2002, effective Jan. 30, 2003. Amended: Filed Nov. 1, 2007, effective July 30, 2008.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 375.1000–375.1018, see RSMo 2000 and RSMo Supp. 2007.*

20 CSR 100-1.020 Misrepresentation of Policy Provisions in Claims Settlement

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007(1), RSMo.

(1) An insurer who engaged in one or more of the following acts or practices shall be deemed to be engaged in "misrepresenting policy provisions" as used in section 375.1007(1), RSMo. This rule is not intended to be all inclusive and acts or practices not enumerated in this rule may also be deemed misrepresentation.

(A) No insurer shall fail to fully disclose to first-party claimants all pertinent benefits, coverages or other provisions of an insurance policy under which a claim is presented.

(B) No insurance producer shall conceal from any first-party claimant the benefits, coverages or other provisions of any insurance policy when these benefits, coverages or other provisions are pertinent to a claim.

(C) No insurer shall deny any claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(D) No insurer shall deny any claim based upon the insured's failure to submit a written notice of loss within a specified time following any loss, unless this failure operates to prejudice the rights of the insurer.

(E) No insurer shall request a first-party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(F) No insurer shall issue any draft in partial settlement of a claim under a specific coverage, when endorsement of the draft would totally release the insurer or its insured from liability.

AUTHORITY: section 374.045, RSMo 2000 and sections 375.1000–375.1018, RSMo 2000 and RSMo Supp. 2007. This rule was previously filed as 4 CSR 190-10.060(3). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Aug. 16, 1978, effective Dec. 11, 1978. Amended: Filed Sept. 11, 1980, effective Feb. 16, 1981. Amended: Filed Sept. 14, 1981, effective Jan. 15, 1982. Amended: Filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Jan. 5, 1987, effective June 1, 1987. Amended: Filed Aug. 4, 1987, effective Dec. 24, 1987. Amended: Filed Dec. 9, 1988, effective April 28, 1989. Amended: Filed Nov. 2, 1989, effective Feb. 15, 1990. Emergency amendment filed Feb. 21, 1990, effective March 5, 1990, expired June 2, 1990. Amended: Filed Feb. 26, 1990, effective June 11, 1990.*

Amended: Filed Dec. 12, 1990, effective June 10, 1991. Amended: Filed Oct. 1, 1996, effective June 30, 1997. Amended: Filed July 12, 2002, effective Jan. 30, 2003. Amended: Filed Nov. 1, 2007, effective July 30, 2008.

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 375.1000–375.1018, see RSMo 2000 and RSMo Supp. 2007.*

20 CSR 100-1.030 Failure to Acknowledge Pertinent Communication

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007(2), RSMo.

(1) Every insurer, upon receiving notification of claim from any first-party claimant within ten (10) working days, shall acknowledge the receipt of the notification unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of this acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) An appropriate reply shall be made within ten (10) working days on all communications from any claimant which reasonably suggests that a response is expected.

(3) Every insurer, upon receiving notification of claim, promptly shall provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this section within ten (10) working days of notification of a claim shall constitute compliance with section (1) of this rule.

AUTHORITY: sections 374.045, RSMo Supp. 1996 and 375.1000–375.1018, RSMo 1994. This rule was previously filed as 4 CSR 190-10.060(4). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Aug. 16, 1978, effective Dec. 11, 1978. Amended: Filed Sept. 11, 1980, effective Feb. 16, 1981. Amended: Filed Sept. 14, 1981, effective Jan. 15, 1982. Amended: Filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Jan. 5, 1987, effective June 1, 1987. Amended: Filed Aug. 4, 1987, effective Dec. 24, 1987. Amended: Filed Dec. 9, 1988, effective April 28, 1989. Amended: Filed Nov. 2, 1989, effective Feb. 15, 1990. Emergency amendment filed Feb. 21, 1990, effective March 5, 1990, expired June 2, 1990. Amended: Filed Feb. 26, 1990, effective June 11, 1990. Amended: Filed Dec. 12, 1990, effective June 10, 1991. Amended: Filed Oct. 1, 1996, effective June 30, 1997.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995; 375.1000–375.1018 see Missouri Revised Statutes 1994.*

20 CSR 100-1.040 Standards for Prompt Investigation of Claims
(Rescinded July 30, 2008)

AUTHORITY: section 374.045, RSMo Supp. 1996 and sections 375.1000–375.1018, RSMo 1994. This rule was previously filed as 4 CSR 190-10.060(5). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Aug. 16, 1978, effective Dec. 11, 1978. Amended: Filed Sept. 11, 1980, effective Feb. 16, 1981. Amended: Filed Sept. 14, 1981, effective Jan. 15, 1982. Amended: Filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Jan. 5, 1987, effective June 1, 1987. Amended: Filed Aug. 4, 1987, effective Dec. 24, 1987. Amended: Filed Dec. 9, 1988, effective April 28, 1989. Amended: Filed Nov. 2, 1989, effective Feb. 15, 1990. Emergency amendment filed Feb. 21, 1990, effective March 5, 1990, expired June 2, 1990. Amended: Filed Feb. 26, 1990, effective June 11, 1990. Amended: Filed Dec. 12, 1990, effective June 10, 1991. Amended: Filed Oct, 1, 1996, effective June 30, 1997. Rescinded: Filed Nov. 1, 2007, effective July 30, 2008.

20 CSR 100-1.050 Standards for Prompt, Fair and Equitable Settlement of Claims

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007(4), RSMo.

(1) Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers.

(A) Within fifteen (15) working days after the submission of all forms necessary to establish the nature and extent of any claim, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny any claim on the grounds of a specific policy provision, condition or exclusion unless reference to that provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(B) If a claim is denied for reasons other than those described in subsection (1)(A), an appropriate notation shall be made in the claim file of the insurer.

(C) If the insurer needs more time to determine whether a claim should be accepted or denied, it shall so notify the first-party claimant within the time otherwise allotted for acceptance or denial, giving the reasons more time is needed. If the investigation remains incomplete, the insurer, within forty-five (45) days from the date of the initial notification and every forty-five (45) days after, shall send the claimant a letter setting forth the reasons additional time is needed for investigation.

(D) No insurer shall fail to settle any first-party claim on the basis that responsibility for payment should be assumed by others except as otherwise may be provided by policy provisions.

(E) No insurer shall continue negotiations or settlement of any claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. The notice shall be given to first-party claimants thirty (30) days and to third-party claimants sixty (60) days before the date on which the time limit may expire.

(F) No insurer shall make any statement which indicates that the rights of a third-party claimant may be impaired if a form of release is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

(G) All insurers offering cash settlements of first-party long-term disability income claims shall develop a present value calculation of future benefits utilizing contingencies, such as mortality, morbidity and interest rate assumptions, etc., appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by him/her at the time a settlement is entered into. A copy of the amount with the calculations also shall be given to the insured at the time the insured is first approached regarding settlement. This acknowledgment of advice of probable value of the contract, together with a copy of the calculations used to arrive at the amount, shall be maintained in the claim file whenever a cash settlement is accepted by the insured. This regulation shall not apply to the settlement of liability insurance claims or structured settlements made in settlement of liability insurance claims. The furnishing of a present value calculation to an insured shall not be construed to imply or impose any liability on the insurer.

(H) Interest at the rate of nine percent (9%) per annum shall be paid on all life

insurance policy proceeds upon the death of the insured if the insurer fails to pay the proceeds of the policy within thirty (30) days of submission of proof of death and receipt of all necessary proofs of loss. Payment shall include interest at nine percent (9%) per annum, unless another rate has been agreed upon, from the date of death of the insured until the date the claim is paid.

(2) Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance.

(A) Where liability and damages are reasonably clear, insurers shall not recommend that third-party claimants make claim under their own policies to avoid paying claims under the insurer's insurance policy or insurance contract.

(B) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(C) Insurers, upon the claimant's request, shall include the first-party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first-party claimants, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect this recovery. The deduction may then be for only a *pro rata* share of the allocated loss adjustment expense.

(D) Estimates.

1. If an insurer prepares an estimate of the cost of automobile repairs, the estimate shall be in an amount for which it may be reasonably expected the damages can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one (1) or more conveniently located repair shops.

2. No insurer may prepare an estimate, except an estimate prepared at the insured's request by a person or entity having no contractual relationship with the insurer, of the cost of automobile repairs based on the use of an after-market part, unless each of the following conditions are met:

A. The insurer discloses to the claimant in writing, either on the estimate or in a separate document attached to the estimate, the following information in no smaller than ten (10)-point type: This estimate has been prepared based on the use of an automobile part(s) not made by the original equipment manufacturer. Parts used in the repair of your vehicle by other than the original manufacturer are required to be at least equal in like, kind and quality in terms of fit, quality and performance to the original manufacturer parts they are replacing. All after-market parts installed on the vehicle shall be clearly identified on the repair estimate;

B. No insurer shall require the use of after-market parts in the repair of an automobile unless the after-market part is at least equal in like, kind and quality to the original part in terms of fit, quality and performance. Insurers specifying the use of after-market parts shall consider the cost of any modifications which may become necessary when making the repair; and

C. All after-market parts, which are subject to this regulation and manufactured after October 31, 1991, shall carry sufficient permanent identification so as to identify its manufacturer. This identification shall be accessible to the extent possible after installation.

3. Definitions.

A. Insurer includes any person authorized to represent the insurer with respect to a claim and who is acting within the scope of the person's authority.

B. After-market part, for purposes of this regulation, means sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels, not made by the original equipment manufacturer.

(E) When the amount claimed is reduced because of betterment or depreciation, all information for the reduction shall be contained in the claim file. These reductions shall be itemized and shall be appropriate in amount.

(F) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(G) The insurer shall not use as a basis for cash settlement with a first-party claimant an amount which is less than the amount which the insurer would pay if repairs were made, other than in total loss situations, unless the amount is agreed to by the insured.

(3) Standards for Prompt, Fair and Equitable Settlements Applicable to Health Insurance.

(A) Precertification. An insurer may require that claimants for health insurance benefits have their course of treatment certified in advance of incurring the claim based upon the course of treatment, so long as the following requirements are met:

1. The rules of the insurer for precertification must be fully disclosed to the covered person in advance of any incurred claim or course of treatment; and

2. Precertification determinations must be made in a prompt, fair and equitable manner.

(B) Denial of Precertified Claims.

1. No insurer may deny, in whole or in part, any claim for health insurance benefits if—

A. The claim is based upon a course of treatment which has been precertified; and

B. The claim denial is based upon one (1) or more of the following reasons:

(I) The claim or course of treatment was not medically necessary; or

(II) The claim or course of treatment was experimental.

2. The provisions of paragraph (3)(B)1. of this rule do not apply to any claim against an insurer which has a contract—

A. With the health care provider who provided the treatment upon which the claim is based; and

B. Which requires the health care provider to hold the insured harmless from the denial of the claim.

(4) Standards for Prompt Investigations of Claims. Every insurer shall complete an investigation of a claim within thirty (30) days after notification of the claim, unless the investigation cannot reasonably be completed within this time.

AUTHORITY: section 374.045, RSMo 2000 and sections 375.1000–375.1018, RSMo 2000 and RSMo Supp. 2007. This rule was previously filed as 4 CSR 190-10.060(6), (7), and (11). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Aug. 16, 1978, effective Dec. 11, 1978. Amended: Filed Sept. 11, 1980, effective Feb. 16, 1981. Amended: Filed Sept. 14, 1981, effective Jan. 15, 1982. Amended: Filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Jan. 5, 1987, effective June 1, 1987. Amended: Filed Aug. 4, 1987, effective Dec. 24, 1987. Amended: Filed Dec. 9, 1988, effective April 28, 1989. Amended: Filed Nov. 2, 1989, effective Feb. 15, 1990. Emergency amendment filed Feb. 21, 1990, effective March 5, 1990, expired June 2, 1990. Amended: Filed Feb. 26, 1990, effective June 11, 1990. Amended: Filed Dec. 12, 1990, effective June 10, 1991. Amended: Filed May 2, 1991, effective Oct. 31, 1991. Emergency amendment filed May 15, 1991, effective May 25, 1991, expired Sept. 21, 1991. Amended: Filed May 16, 1991, effective Oct. 31, 1991. Emergency amendment filed Oct. 3, 1991,*

effective Oct. 13, 1991, expired Feb. 9, 1992. Amended: Filed Oct. 3, 1991, effective March 9, 1992. Amended: Filed Oct. 1, 1996, effective June 30, 1997. Amended: Filed Nov. 1, 2007, effective July 30, 2008.

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 375.1000–375.1018, see RSMo 2000 and RSMo Supp. 2007.*

20 CSR 100-1.060 Standards for Prompt, Fair, and Equitable Settlements under Health Benefit Plans

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007, RSMo 2000, and sections 376.383 and 376.384, RSMo Supp. 2008.

(1) Scope. This rule applies to all claims submitted by a claimant to a health carrier or its third-party contractor after September 1, 2009, and that health benefit plan is either a fully-insured group health benefit plan where the provider submits claims as a participating provider or is an individual health benefit plan.

(2) Definitions. As used in sections 376.383 and 376.384, RSMo, and in the regulations promulgated pursuant thereto—

(A) "Acknowledgment of the date of receipt" shall mean a written notice, whether made in electronic or nonelectronic format, to the claimant by the health carrier or its third-party contractor that it received a claim and setting forth the date on which the claim was received;

(B) "Claim" shall mean a written request or demand by a claimant for the payment of health care services provided, whether made in an electronic format by a provider or in an electronic or nonelectronic format by an insured or enrollee;

(C) "Confirmation of receipt" shall mean a written notice, made in electronic or nonelectronic format, to the health care provider by the health carrier or its third-party contractor that it received an electronically-filed claim. A confirmation of receipt may also constitute an acknowledgement of the date of receipt if it meets the requirements of subsection (A) of this section;

(D) "Date of claim payment" shall mean the date the health carrier or its third-party contractor mails or sends the payment as indicated by the date of—

1. The postmark, if a claim payment is delivered by the U.S. Postal Service;

2. The electronic transmission, if the payment is made electronically;

3. The delivery of the claim payment by a courier; or

4. The receipt by the claimant, if the claim payment is made other than as provided in paragraphs (2)(D)1. through (2)(D)3., above;

(E) "Date of denial" shall mean the date when the health carrier or its third-party contractor mails or electronically sends a denial;

(F) "Date of receipt" shall mean the date upon which the health carrier or its third-party contractor first receives a claim or other information relevant and pertinent to the claim, indicated by the date of—

1. Presumed receipt in subsection (3)(B), below, if a claim is delivered in that manner;

2. The electronic transmission, if the claim is delivered electronically; or

3. The date stamped by the health carrier or its third-party contractor, if the claim is delivered in a manner other than those described above;

(G) "Deny" or "denial" shall mean the health carrier or its third-party contractor mails or sends an electronic or written notice to the claimant refusing to reimburse all or part of the claim, which includes each reason for the denial;

(H) "Health benefit plan" shall mean health benefit plan as defined in section 376.1350, RSMo;

(I) "Notification of claim" shall mean any notification to a carrier or its third-party contractor, by a claimant, which reasonably apprises the health carrier of the facts pertinent to a claim;

(J) "Pay" or "payment" shall mean the health carrier or its third-party contractor mails or sends electronic or written notice including remuneration to the claimant that reimburses all or part of the claim;

(K) "Processing days" shall mean the number of days the health carrier or its third-party contractor has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a reasonable request for additional necessary information;

(L) "Request for additional information" shall mean when the health carrier or its third-party contractor requests, in writing, whether made in electronic or nonelectronic format, additional necessary information from the claimant to determine if all or part of the claim will be reimbursed. Such a request must meet the following requirements:

1. It shall describe with specificity the clinical and other information to be included in the response; and

2. It shall be relevant and necessary for the resolution of the claim;

(M) "Suspension date" shall mean the date the health carrier or its third-party contractor mails or sends electronic written notice that the claim is suspended;

(N) "Third-party contractor" shall mean an entity or person contracted with the health carrier to receive or process claims for reimbursement of health care services; and

(O) "Working days" shall mean the number of consecutive days not counting weekends or federal holidays.

(3) Communications Between Entities Subject to This Rule.

(A) An entity subject to this rule may deliver written communication as follows:

1. By U.S. mail, first-class delivery; by U.S. mail, return receipt requested; or by overnight mail, and maintain a copy of the receipt or signature card acknowledging receipt of delivery;

2. Electronically and maintain proof of the electronically submitted communication;

3. If the entity accepts facsimile transmissions for the type of communication being sent, then fax the communication and maintain proof of the facsimile transmission; or

4. Hand delivery of the communication and maintain a copy of the signed receipt acknowledging the hand delivery.

(B) Communication is presumed to be received as follows:

1. On the date shown by a date stamp showing the actual date received, if the sender used U.S. mail, first-class delivery; or

2. On the date the delivery receipt is signed, if the sender used an overnight delivery service or the U.S. mail, return receipt requested, or if the sender hand delivered the communication.

(4) Standards for Prompt, Fair, and Equitable Settlements under Health Benefit Plans.

(A) Every health carrier or third-party contractor, upon receiving notification of a claim from a claimant, shall, within ten (10) working days, do one (1) or more of the following—

1. Send an acknowledgment of the date of receipt;

2. Send written notice of status of the claim, whether made in electronic or nonelectronic format, with a request for additional information and from whom it is requested, such as the claimant, the patient, or another health care provider;

3. Pay the total amount of the claim in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee;

4. Pay the portion of the claim for which the health carrier acknowledges liability in accordance with the contract between the

health carrier and the health care provider or the health carrier and the insured or enrollee, suspend the remainder of the claim, and send a request for additional information;

5. Pay the portion of the claim for which the health carrier acknowledges liability in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee, and deny a portion of the claim and specify each reason for the denial; or

6. Deny the claim in its entirety and specify each reason for such denial.

(B) If notice of the claim was received as an electronically filed claim, the health carrier or its third-party contractor shall issue confirmation of receipt of the claim within one (1) working day of its receipt to the claimant that submitted the claim electronically.

(C) If additional information is requested, an appropriate reply shall be made within fifteen (15) processing days of receiving any additional claim information from the person from whom the information was requested. An appropriate reply shall mean payment of all or the undisputed portion of the claim, denial of the claim, suspension of the claim, or a final request for additional information.

(D) All denials, suspensions, or requests for additional information shall be communicated in writing to the claimant and shall include specific reasons why the action was taken or why the information is needed.

(5) Health carriers must conduct a reasonable investigation before denying or suspending a claim in whole or in part. Health carriers shall not suspend or deny claims for lack of information until it has requested the pertinent additional information on two (2) separate occasions.

(A) Claims.

1. If a claim or portion of a claim remains unpaid after forty-five (45) days after notification of the claim, interest shall accrue beginning from the forty-fifth day after the date of receipt of the claim at a rate equal to one percent (1%) per month of the unpaid balance of the claim until the claim is paid. The interest shall be payable by the health carrier to the health care provider, individual insured, enrollee, or other entity submitting the claim. If the health carrier denies or suspends a claim that is subsequently determined to be the liability of the health carrier, the health carrier will be responsible for the interest from the forty-fifth day of the original date of notification of the claim until the claim is actually paid.

2. Any improperly denied claims that are subsequently determined to be payable shall have interest calculated from the forty-fifth day after the date of receipt of the claim.

3. The health carrier may wait until the claimant's aggregate interest payments reach five dollars ($5) before making interest payment to the claimant.

(B) Duties of the Health Carrier.

1. When a health carrier pays or denies a claim, it shall explain in sufficient detail how each item or service was reimbursed. Specifically, if the health carrier has a contract rate with the health care provider, the health carrier shall indicate which items or services are included in the reimbursement and which items are not included in the reimbursement.

2. Pursuant to the requirements of 20 CSR 100-8.040, health carriers shall maintain and legibly date stamp all documentary material related to the pertinent events of a claim. Pertinent events shall include, but not be limited to, the date of the notification of claim, date of claim payment, date of denial, suspension date, reason for denial or suspension, amount paid, amount denied, amount suspended, date additional information is requested, the nature of the specific additional information requested, and the date such additional information was received.

3. After notification of a claim, if any information on the claim that affects the amount of benefits payable is changed or omitted in the processing of the claim, including any electronic edits, the health carrier or its third-party contractor shall notify the claimant of the modification in writing with specificity.

4. Any contractual agreement between the health carrier and any of its third-party contractors that receives or processes claims, obtains the service of a health care provider to provide health care services, or issues verifications or pre-authorizations may not be construed to limit the health carrier's authority or responsibility to comply with all applicable statutory and regulatory requirements of this rule or of sections 376.383 and 376.384, RSMo.

5. Contracts between health care providers, health carriers, and their respective third-party contractors shall not extend the statutory or regulatory time frames set forth in this rule or in sections 376.383 and 376.384, RSMo.

(C) Complaints Against Health Carriers. Every complaint made by a health care provider to the director shall include: the health care provider's name, address, and daytime phone number; the health carrier's name; the date of service and date(s) the claim was filed with the health carrier; all relevant correspondence between the health care provider and the health carrier, including requests from the health carrier for additional information; a copy of the confirmation of receipt or acknowledgment of the date of receipt of the claim from the health carrier or its third-party contractor, if available; and additional information which the health care provider believes would be of assistance in the department's review.

AUTHORITY: section 376.1007, RSMo 2000 and sections 374.045, 376.383, and 376.384, RSMo Supp. 2008. Original rule filed Sept. 5, 2008, effective May 30, 2009.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995, 2008; 376.383, RSMo 1998, amended 2001; 376.384, RSMo 2001; and 376.1007, RSMo 1993.*

20 CSR 100-1.070 Identification Cards Issued by Health Carriers

PURPOSE: This rule sets forth the requirements for an identification card issued to insureds or enrollees by health carriers offering health benefit plans.

(1) Applicability.

(A) This rule applies to all health carriers offering or providing a plan of health insurance, health benefits, or health services to individuals and groups.

(B) The provisions of this rule shall not apply to identification cards issued to individuals or groups that relate solely to the provision of prescription drug benefits.

(2) Definitions. As used in this section—

(A) "Health benefit plan" shall mean health benefit plan as defined in section 376.1350(18), RSMo; and

(B) "Health carrier" shall mean health carrier as defined in section 376.1350(22), RSMo.

(3) Identification Cards.

(A) An identification card or similar document issued to insureds or enrollees shall include the following information:

1. The name of the enrollee or insured;

2. The first date on which the enrollee or insured became eligible for benefits under the plan or a toll-free number that a health care provider may use to obtain such information; and

3. Indicate that the health benefit plan offered by the health carrier is regulated by the Department of Insurance, Financial Institutions and Professional Registration by placing "Fully Insured" on the front.

(B) Nothing shall prohibit the issuer of a health benefit plan from using an identification

card containing a magnetic strip or other technological component enabling the electronic transmission of information, provided that the information required in this section is printed on the card.

(C) The requirements of this section shall apply as follows:

1. Beginning on March 1, 2010, for all new health benefit plans issued on or after March 1, 2010; and

2. On the first plan anniversary after March 1, 2010, for all health benefit plans already in effect on March 1, 2010.

AUTHORITY: section 376.1007, RSMo 2000 and sections 374.045, 376.383, and 376.384, RSMo Supp. 2008. Original rule filed Sept. 5, 2008, effective May 30, 2009.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995, 2008; 376.383, RSMo 1998, amended 2001; 376.384, RSMo 2001; and 376.1007, RSMo 1993.*

20 CSR 100-1.100 Claims Involving Public Adjusters or Solicitors

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007(4), RSMo as applied to claims involving a public adjuster or solicitor.

(1) No insurance company authorized to do the business of insurance in Missouri shall make payment of any insurance claim, or any portion of a claim, to a public adjuster or solicitor on account of services rendered by a public adjuster or solicitor to an insured unless the name of the insured is added as a joint payee on any claim check or draft. The payment, whether by check, draft or otherwise, should be sent to the address designated by the insured.

AUTHORITY: section 374.045, RSMo 2000 and sections 375.1000–375.1018, RSMo 2000 and RSMo Supp. 2007. This rule was previously filed as 4 CSR 190-10.060(10). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Aug. 16, 1978, effective Dec. 11, 1978. Amended: Filed Sept. 11, 1980, effective Feb. 16, 1981. Amended: Filed Sept. 14, 1981, effective Jan. 15, 1982. Amended: Filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Jan. 5, 1987, effective June 1, 1987. Amended: Filed Aug. 4, 1987, effective Dec. 24, 1987. Amended: Filed Dec. 9, 1988, effective April 28, 1989. Amended: Filed Nov. 2, 1989, effective Feb. 15, 1990. Emergency amendment filed Feb. 21, 1990, effective March 5, 1990, expired June 2, 1990. Amended: Filed Feb. 26, 1990, effective June 11, 1990. Amended: Filed Dec. 12, 1990, effective June 10, 1991. Amended: Filed Oct, 1, 1996, effective June 30, 1997. Amended: Filed Nov. 1, 2007, effective July 30, 2008.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 375.1000–375.1018, see RSMo 2000 and RSMo Supp. 2007.*

20 CSR 100-1.200 Claims Practices When Retrospective Premiums Paid

PURPOSE: This regulation prohibits policyholders from settling their own losses, pursuant to the provisions of section 374.045, RSMo and implements section 375.445, RSMo.

(1) No insurer, insurance producer or representative shall permit or allow a policyholder, whether corporate or individual, to engage in the settlement of third-party liability claims against that policyholder's liability coverage on behalf of the insurer when premiums payable for third-party liability coverage are calculated or are to be modified on the basis of third-party liability losses, loss payments or settlement expenses.

AUTHORITY: section 374.045, RSMo 2000 and section 375.445, RSMo Supp. 2007. This rule was previously filed as 4 CSR 190-10.055. Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Amended: Filed July 12, 2002, effective Jan. 30, 2003. Amended: Filed Nov. 1, 2007, effective July 30, 2008.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 375.445, RSMo 1967, amended 2007.*

20 CSR 100-1.300 Assignment of Benefits

PURPOSE: This rule implements and interprets the provisions of section 376.427, RSMo.

(1) Definitions. For the purpose of this regulation—

(A) Assignment means any written authorization by an insured directed to an insurer instructing the insurer to pay benefits for health care services to the provider of services;

(B) Claim means proof of claim forms, bills, itemized charges and all other documents reasonably required by an insurer to investigate, adjust and pay benefits pursuant to the terms of a contract;

(C) Contract means an individual or group health insurance policy or contract which provides coverage on an expense-incurred basis and is issued by an insurer doing business in Missouri;

(D) Health care services means medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service and optometric services;

(E) Insured means any person entitled to benefits under a contract issued by an insurer;

(F) Insurer means any insurance company issuing or writing any policy of accident and sickness insurance and any health services corporation subject to the provisions of sections 354.010–354.380, RSMo; and

(G) Provider means a physician, hospital, dentist, podiatrist, chiropractor, pharmacy, licensed ambulance service or optometrist licensed by this state.

(2) Upon receipt of an assignment of benefits made by the insured to a provider, an insurer subject to the provisions of section 376.427.1(3), RSMo and not excluded pursuant to the provisions of section 376.427.4, RSMo shall issue the instrument for payment of the benefits for health care services in the name of the provider.

(3) All payments shall be made within thirty (30) days of the receipt by the insurer of all documents reasonably needed to adjudicate the claim.

(4) All contracts shall contain a provision stating that benefits payable under the contract shall be paid, with or without an assignment of benefits from the insured, to public hospitals and clinics for health care services and supplies provided to the insured if a proper claim is submitted by the public hospital or clinic as specified in section 376.778.2, RSMo and if benefits have not been paid to the insured prior to receipt of the claim by the insurer. Payment of benefits to the public hospital or clinic by the insurer shall discharge the insurer from all liability to the insured to the extent of benefits paid. Under no circumstances, however, shall payment of duplicate benefits to both the insured and the public hospital or clinic for the same services or supplies be required.

AUTHORITY: sections 374.045 and 376.778, RSMo 1986 and 376.427, RSMo Supp. 1990. Original rule filed April 25, 1991, effective Sept. 30, 1991.*

**Original authority: 374.045, RSMo 1967; 376.778, RSMo 1983; and 376.427, RSMo 1990.*