

Missouri External Claim Review Information Packet

Please read this packet carefully. This packet contains important information about how to request an External Claim Review in the State of Missouri.

I. External, Independent Review Process

A. Filing

You must send your request for External, Independent Review in writing to:

Name: Director of Insurance
Missouri Department of Insurance
Address:P.O. Box 690
Jefferson City, MO 65102
Phone: 800-726-7390
FAX: 513-751-1958

B. Consumer Grievance Process

Your request for External, Independent Review will be processed by the Department of Insurance as any other consumer complaint. The Department of Insurance will send an inquiry to your insurer requesting that insurer to respond in writing with their position and all supporting documentation used by the insurer to make the decision. The Department of Insurance will attempt to resolve the issue with your insurer.

C. Independent Review Organization Process

If the Director of Insurance of the Department of Insurance determines an appeal is unresolved after completion of the Department of Insurance's consumer complaint process, the department will refer the unresolved appeal to an independent review organization.

The Department of Insurance will provide the independent review organization, and upon request, you, your representative or insurer copies of all medical records and any other relevant documents which the Department of Insurance has received from any party. You, your representative or insurer may review all information submitted to the independent review organization for consideration.

You, your representative or the insurer may also submit additional information to the Department of Insurance which will be forwarded to the independent review organization. All additional information must be received by the Department of Insurance. If you, your representative or the insurer has information which contradicts information already provided the independent review organization, they should provide it as additional information. All additional information should be received by the Department of Insurance within fifteen (15) working days from the date the Department of Insurance mailed that party copies of the information provided the independent review organization. An envelope's postmark will determine the date of mailing. Information may be submitted to the Department of Insurance by means other than mail if it is in writing, typeset or easily transferred into typeset by the Department of Insurance's technology and a date of transmission is easily determined by the Department of Insurance. At the Department of Insurance's discretion, additional information which is received past the fifteen (15)-working day deadline may be submitted to the independent review organization.

The independent review organization will request from the Department of Insurance any additional information it wants. The Department of Insurance will gather the requested information from you, your representative or the insurer or other appropriate entity and provide it to the independent review organization. If the Department of Insurance is unable to obtain the requested information, the independent review organization will base its opinion on the information already provided.

D. Decision

Within twenty (20) calendar days of receiving all material, the independent review organization will submit to the Department of Insurance its opinion of the issues reviewed. If the independent review organization requires additional time to complete its review, it will request in writing from the Department of Insurance an extension in

the time to process the review. Such a request will include the reasons for the request and a specific time at which the review is expected to be complete.

After the Department of Insurance receives the independent review organization's opinion, the Director of Insurance will issue a decision which will be binding upon you and the insurer.

II. Obtaining Medical Records

A. Requesting Medical Records

You have the right to ask for a copy of medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under any State Regulations remain confidential.

III. Documentation

If you decide to request a review, you must give the person who will be responsible for processing the review any material justification or documentation for the review at the time the review is filed. You must also give that person the address and phone number where you can be contacted.

IV. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other person.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

VI. Definitions

Grievance means a written complaint submitted by you or on your behalf regarding the:

- (a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- (b) Claims payment, handling or reimbursement for health care services; or
- (c) Matters pertaining to the contractual relationship between you and a health carrier.

Utilization review, 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, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage.