



COLORADO

Department of
Regulatory Agencies

Division of Insurance

When Your Health Insurance Carrier Says **NO**



Your Rights Regarding Pre-authorization and Appeal Procedures

What Happens When Your Health Insurance Carrier Says NO

Most health carriers today carefully evaluate requests to see a specialist or have certain medical procedures performed. A medical professional employed by the health carrier reviews the request for covered services made by your health care provider to make sure the requested services are medically necessary, appropriate, efficient or effective. This process is known as “utilization review”.

Any time your health carrier denies benefits for covered services that you and your health care provider feel are medically necessary or have medical evidence proving that the services aren't subject to a contractual exclusion, you have the right to challenge that decision. The decision to deny benefits is known as an “adverse determination”. This brochure is a guide to the rights you have when your health carrier says “no”. It contains summary information about standard and expedited utilization review, emergency services, “peer-to-peer conversations”, first level reviews, voluntary second level reviews, and independent external reviews. Colorado law requires all health policies subject to the state insurance laws to include the same procedures.



State insurance laws do not apply to:

- Federal employee benefit plans;
- Medicare or Medicaid plans;
- Employer-provided plans that are based in another state; nor
- Self-insured (self-funded) health plans.

Some self-insured employers use a health insurance company to administer their plans, so it may not be obvious that they are self-insured. Check your health plan ID card - if it has a “CO-DOI” designation on it, your plan is subject to Colorado’s insurance laws and rules.

Standard Utilization Review

Prospective Review

A prospective review may be requested by your health care provider for preauthorization of a hospital admission or a course of treatment (such as a procedure or a visit to a specialist). Your health carrier must notify you and your provider of its determination within 15 days of receiving the request. Under certain circumstances, this period of time may be extended.



Retrospective Review

A retrospective review may be performed when you or your health care provider submit a claim for services or treatment you've already received. The purpose of this review is to determine whether the services and/or treatment were medically necessary, appropriate, efficient, or effective. Your health carrier must notify you and your provider of its determination within 30 days of receiving the request. Under certain circumstances, this period of time may be extended.

Expedited Utilization Review

Sometimes your medical condition may require you to receive treatment or services rather quickly although an emergency may not exist. If this is the case, your health care provider may submit an urgent care request to your health carrier, which requires your health carrier to conduct its utilization review in a shorter period of time than that allowed for a standard utilization review.

An urgent care request can be made:

1. Before hospitalization or treatment begins, or
2. While you are hospitalized or undergoing treatment.

In both of these circumstances, the health carrier must take your health condition into account when making its determination.

If hospitalization or treatment has not started, the health carrier must notify you and your health care provider of its determination as soon as possible, but no more than 72 hours after receiving the request.



If you are in the hospital or undergoing treatment and your health care provider wants to extend your hospital stay or continue your treatment beyond what was originally authorized, your health care provider should make the request at least 24 hours prior to the time hospitalization or treatment was supposed to end. The health carrier must notify you and your health care provider of its determination as soon as possible, but no more than 24 hours after receiving the request.

Notification Requirements for Adverse Determinations

Anytime a request for benefits for covered services is denied, your health carrier must notify you and your health care provider. With standard utilization review, the notice may be sent in writing or electronically. With expedited utilization review, the notice may be provided orally, in writing, or electronically. If notice of a denial is given orally, written notice must also be given within 3 days of oral notification.

All notices of adverse determination must include all the following:

- ✓ The specific reason(s) for the denial and the reference to the plan provision(s) on which the denial is based.
- ✓ A description of any additional material or information that may improve the benefit request, and why that material or information is necessary.
- ✓ A copy of any internal rule, guidance, etc., that was relied upon by the health carrier, or information on how to request a free copy of what was relied on.
- ✓ An explanation of the clinical or scientific basis for a denial based on medical necessity or experimental treatment or information on how you can request a free explanation.
- ✓ A description of the carrier's review (appeal) procedures and the applicable time limits, and notification of your right to appeal.

Emergency Services

Health carriers cannot require you to get prior authorization for emergency services if a person, having an average knowledge of medicine and acting reasonably, would have believed that an emergency medical condition or a life or limb-threatening emergency existed.



Peer-to-peer Conversations



Any time a prospective review results in an adverse determination, your health care provider may ask for a “peer-to-peer conversation”; that is, an opportunity to speak to the reviewer who made the adverse determination on behalf of the health carrier. The conversation must take place within 5 days of receipt of the request. If this conversation does not resolve the issue, you may appeal the adverse determination. A peer-to-peer conversation is optional. You can appeal without such conversation ever taking place

Appeals Procedure

If you are not satisfied with your health carrier’s decisions, you have the right to appeal them. All health plans subject to state insurance law must have written procedures for handling such requests for review. In this brochure, we summarize the basic process carriers must follow. For details of your carrier’s specific procedures, check your member handbook or call your health carrier’s customer service department.

Individual Health Plans

First Level Review

You may request a first level review within 180 days of receiving an adverse determination. You have the right to submit or present additional materials. You have the option of submitting a written appeal or requesting an appeal review meeting. If you choose a meeting, you have the right to appear in person at the review meeting or attend via teleconference. You are only entitled to one of these options.

The first level review of a written appeal will be conducted by a physician in consultation with clinical peers, none of who were involved in the initial adverse determination. The carrier must notify you of its decision, in writing or electronically, within 30 days of receiving your request or following the appeal review meeting. It should also provide you with information about requesting an independent external review.

Procedures for conducting an appeal review meeting must include the following:

- ✓ The review meeting must be scheduled within 60 days of receiving your request and you must be notified in writing at least 20 days in advance of the meeting date;
- ✓ You must be given the opportunity to be present and be given the opportunity to provide additional written comments, documents, records, etc., for review;
- ✓ Both you and the health carrier may have an attorney present;
- ✓ The reviewer or the review panel must consider all of the comments, documents, records, etc., submitted; and
- ✓ The written decision must be issued within 7 days of the review meeting.

Group Health Plans

First level Review

You may request a first level review within 180 days of receiving an adverse determination. Most carriers will require you to submit your request in writing. The first level review will be conducted by a physician in consultation with clinical peers, none of who were involved in the initial adverse determination. With your appeal, you have the right to submit written comments, documents, records, and other material relating to the request for benefits. The carrier must notify you of its decision, in writing or electronically, within 30 days of receiving your request. If it upholds its denial, the carrier should also provide you with information about requesting a voluntary second level review or an independent external review.



Voluntary Second Level Review

Health carriers are required to offer a second level review process for those group plan members who are dissatisfied with the first level review decision. You may file a request for one with your carrier within 30 days after receiving the adverse determination from the first review.



The second level review will be conducted by a health care professional, or, if offered by the health carrier, a panel of health care professionals who have appropriate expertise in relation to the case. You always have the right to appear in person at the review meeting or attend via teleconference.

Procedures for conducting a second level review meeting must include the following:

- ✓ The review meeting must be scheduled within 60 days of receiving your request and you must be notified in writing at least 20 days in advance of the review date;
- ✓ You must be given the opportunity to be present and given the opportunity to provide additional written comments, documents, records, etc., for review;
- ✓ Both you and the health carrier may have an attorney present;
- ✓ The reviewer or the review panel must consider all of the comments, documents, records, etc., submitted; and
- ✓ The written decision must be issued within 7 days of the review meeting.

Expedited Appeal Review

Expedited review is available for urgent care requests of adverse determinations including someone who has received emergency services but has not been discharged from a facility. Either you or your health care provider may request an expedited review and the request may be made orally or in writing. The expedited review will be conducted by clinical peers who were not involved in the initial adverse determination. You do not have the right to attend this review, but you do have the right to submit written comments, documents, records, and other materials relating to the request for benefits.



The carrier must notify you of its decision, as quickly as possible, but not more than 72 hours after receiving your request. The decision must be communicated to you or your health care provider by the fastest means. If notice is given orally, written notice must also be given within 3 days of the oral notification. If the expedited review process does not resolve the issue, you or your health care provider may request a voluntary second level appeal (group plans) or request an expedited independent external review.

Notifications

The following information must be included in all notifications:

- ✓ The name, title and qualifying credentials of the reviewer(s);
- ✓ A statement of the reviewer's understanding of the request;
- ✓ The decision, in clear terms; and
- ✓ A reference to the evidence or documentation used as the basis for the decision.

If the review results in an adverse determination, the following must also be included:

- ✓ The specific reason(s) for the adverse determination, including the specific plan provisions and medical rationale;
- ✓ A statement that you have the right to receive copies of all documents, records, and other relevant information;
- ✓ A copy of any internal rule, guideline, etc., that was relied upon;
- ✓ An explanation of the clinical or scientific basis for a denial based on medical necessity or experimental treatment, or information on how you can request a free explanation; and
- ✓ A statement describing the procedures for obtaining an independent external review of the adverse determination.

For first level reviews (both standard and expedited), the notification must include an explanation of the procedures for obtaining a voluntary second level review (if applicable) or an independent external review.

Independent External Review



If you are denied benefits for health services and disagree with your health carrier's adverse determination, you may be able to request an independent external review after the first or second level review. The denial notice sent to you by your health carrier will explain the procedures for obtaining an independent external review.

External Review

Summary of the process:

- ✓ Your request must be submitted in writing to your health carrier within 4 months (for First Level Appeals) or within 60 days (for Voluntary Second Level Appeals) of receiving the final adverse determination.
- ✓ The independent external review will be conducted by an entity certified by the Division of Insurance, and assigned on a rotating basis.
- ✓ For the external review, you may submit new information with your request, if it is different from information provided or considered during the health carrier's internal review process.
- ✓ In most cases, the external reviewer will provide you with written notice of its decision within 45 days after you have filed your request with your health carrier.
- ✓ If your medical condition warrants, the process can be expedited.
- ✓ If the external reviewer reverses your health carrier's decision, your health carrier must approve benefits for the covered services (in accordance with the terms and conditions of your plan).



Medicare and Medicaid

Medicare has a different set of rules for appeals. The requirements in this brochure do not apply. Call the Senior Health Insurance Assistance Program (SHIP) at 888-696-7213 to find out about Medicare's appeals rules.

People on Medicaid may have additional appeal rights. Call Medicaid at 303-866-3513 or 800-221-3943 (toll free outside of Denver metro area) for more information.

If you have a complaint about something other than a denial of coverage resulting from a utilization review decision (such as not getting an appointment with your doctor quickly), call your health carrier's customer service department and ask how to register your complaint. For many carriers, the grievance procedures will be the same for both coverage denials and other types of complaints. Some carriers may have different procedures to handle different types of problems.

For these other types of complaints, first complete the health carrier's review procedures. **If you still are not satisfied, you can contact the Division of Insurance.** You may also contact the Division if you believe the health carrier did not follow the time frames or requirements for the appeals process.

You can file by complaint by sending a brief letter stating the facts of the case to:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Or complete the complaint form on our website: www.dora.colorado.gov/insurancecomplaints

It is important to complete the health carrier's review process before contacting the Division with a complaint. If you have not completed the review process, the Division may refer you to the health carrier.

The Division can:

- ✓ Help you record your complaint against the health carrier.
- ✓ Thoroughly investigate your complaint.
- ✓ Make sure the carrier follows state law.

The Division cannot:

- ✓ Review or force a favorable utilization review decision.
- ✓ Require your carrier to pay for services that are excluded by the policy.
- ✓ Provide legal services that may be needed to settle complicated disputes.

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