Medicare and Medicaid — Different Rules for Appeals

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

People on Medicaid may have additional appeal rights. Call Colorado Medicaid at 800-221-3943 for more information.

At the Colorado Division of Insurance website, you'll find helpful consumer information on all types of insurance, how to resolve problems, information on premium changes filed by insurance companies and much more.

- Visit **askDORA.colorado.gov** and click on "Health Insurance" under the "Consumer Topics" tab for more information.

COLORADO
Department of Regulatory Agencies
Division of Insurance

Division of Insurance
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When Your Health Insurance Company Says NO

COLORADO
Department of Regulatory Agencies
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You have the right to appeal your insurance company's denial of benefits for covered services that you and your healthcare provider (doctor, hospital, etc.) believe are medically necessary.

Appeal Process Steps

- **STEP 1 — Internal Appeal Review Process:**

Asking your insurance company to reconsider the denial. In most situations, you have to go through an internal appeal review before requesting an external appeal review.

- **STEP 2 — External Appeal Review Process:**

Requesting an independent reviewer to review all of the information previously presented, as well as any new information that may be available.

This is the final step in the appeal process.

Expedited Appeal Process

If your medical condition requires it, all levels of the process can be expedited and decisions are required to be made in very short periods of time. Your physician must provide the medical reason for needing to use the expedited appeal process.

Reviews are done to determine if services and/or treatments are medically necessary, appropriate, efficient, or effective.

A review may be requested by your healthcare provider (doctor, hospital, etc.) when requesting a ***preauthorization*** of the services. Your insurance company must notify you and your provider of its determination within **15 days** of receiving the request unless more time has been requested.

The review may also be performed for services or treatment you've already received when a claim is sent to your insurance company. Your insurance company must notify you and your provider of its determination within **30 days** of receiving the claim unless more time has been requested.

If the review results in an **adverse determination** (a denial), you should receive specific reasons why. You should also receive information describing the next steps you can take in the appeal process.

Internal Appeal Review Process

You have to request a "first level" internal appeal review within 180 days of receiving the denial.

- If you have an individual plan (coverage not from an employer), you have a choice. You can either submit a written appeal or you can request an appeal review meeting. You only get one internal appeal with your insurance company per denied claim.

- If your plan is through your employer, you can only submit a written appeal for this first level, but you do have an option of requesting a second level review meeting if you want one.

External Appeal Process

If your insurance company does not change its decision during the internal appeal process, you have the ability to request that an independent external appeal review be performed.

You have **4 months** (after a first level appeal) or **60 days** (after a voluntary second level appeal, if available) to send your insurance company a request for an external review.

New information can be submitted with your request.

A certified independent external review organization will be assigned by the Division of Insurance after receiving a copy of your request form from the company.

The external reviewer will provide you and your insurance company with written notice of its decision within **45 days** after receiving of the review assignment.

If the external reviewer reverses your company's decision, the company must approve benefits for the covered services (in accordance with the terms and conditions of your plan).