Most health plans today carefully evaluate requests to see a specialist or have certain medical procedures performed. A medical professional employed by the health plan 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 plan 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 plan 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, expedited reviews, and independent external reviews. Colorado law requires all health plans subject to the state insurance laws to follow the same procedures.*

* State insurance laws do not apply to 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 with your employer to find out if your plan is self-insured. Self-insured plans are regulated by a federal law known as ERISA. For information and assistance with complaints about self-insured plans, contact:

U.S. Department of Labor
Pension and Welfare
1100 Main Street, Suite 1200
Kansas City, MO 64105
866-275-7922 (toll free)

STANDARD UTILIZATION REVIEW

Prospective Review

A prospective review may be performed by your health plan when your health care provider requests pre-authorization for a hospital admission or a course of treatment (such as a procedure or a visit to a specialist). Your health plan 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 plan 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 plan, which would require your health plan to conduct its utilization review in a shorter period of time than that allowed for 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 plan must take your health condition into account when making its determination.

If hospitalization or treatment has not started, the health plan 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 is supposed to end. The health plan 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.

ADVERSE DETERMINATIONS

Anytime a request for benefits for covered services is denied, your health plan 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 the oral notification.

All notices of adverse determination must include all of the following:

- The specific reason(s) for the denial, and 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, guideline, etc., that was relied upon by the health plan, or information on how you can request a free copy of what 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.
- A description of the plan's review (appeal) procedures and the applicable time limits, and notification of your right to appeal.

EMERGENCY SERVICES

Health plans **cannot** require you to get prior authorization for emergency services if a person, having 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 with the reviewer who made the adverse determination of behalf of the health plan. 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 a conversation ever taking place.**

APPEALS PROCEDURES

If you are not satisfied with your health plan'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 plans must follow. For details of your plan's specific procedures, check your member handbook or call your health plan's customer service department.

FIRST LEVEL REVIEW

You may request a first level review within 180 days of receiving an adverse determination. Most plans 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. You do not have the right to attend this review, but you do have the right to submit written comments, documents, records, and other material relating to the request for benefits. The plan must notify you of its decision, in writing or electronically, within 30 days of receiving your request.

VOLUNTARY SECOND LEVEL REVIEW

Health plans are required to offer a second level review process for those who are dissatisfied with the first level review decision. You may file a request for one with your plan within 30 days after receiving the adverse determination from the first level review. The second level review will be conducted by a health care professional or, if offered by the health plan, 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 a teleconference. Procedures for conducting a second level review 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/or given the opportunity to provide additional written comments, documents, records, etc., for review;
- both you and the health plan may have an attorney present;
- the reviewer or the review panel must consider all of the comments, documents, records, etc., submitted for the first level review; and
- the written decision must be issued within 7 days of the review meeting.

EXPEDITED REVIEW

Expedited review is available for urgent care requests of adverse determinations and for 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 material relating to the request for benefits. The plan must notify you of its decision, as speedily 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, under some circumstances you or your health care provider may request a voluntary second level appeal or request an independent external review.

NOTIFICATIONS
The following information must be included in all notifications:

- the name, title, and qualifying credentials of the reviewers;
- a statement of the reviewers' 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 by the reviewer, or information on how you can request a free copy of what was relied upon; and
- 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 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 of an independent external review.

INDEPENDENT EXTERNAL REVIEW

If you are denied benefits for general services and disagree with your health plan'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 plan will explain the procedures for obtaining an independent external review. Here is a summary of the process:

- Your request must be submitted in writing to your health plan within 60 days of receiving the final adverse determination from your health plan.
- The independent external review will be conducted by an entity certified by the Division of Insurance, and selected on a rotating basis.
- For the external review, you may submit new information with your request, if it is significantly different from information provided or considered during the health plan's internal review process.
- In most cases, the external reviewer will provide you with written notice of its decision within 30 working days after you have filed your request with your health plan.
- If your medical condition warrants it, the process can be expedited.
- If the external reviewer reverses your health plan's decision, your health plan must approve benefits for the covered services (in accordance with the terms and conditions of the plan).

MEDICARE AND MEDICAID

Medicare has a different set of rules for appeals. The requirements in this brochure do not apply. Call the Division of Insurance at 303-894-7553 or 800-930-3745 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 for more information.

OTHER TYPES OF GRIEVANCES

If you have a complaint about something other than denial of coverage resulting from a utilization review decision (for example, not being able to get an appointment with your doctor soon enough), call your health plan's customer department and ask how to register your complaint. In many plans, the grievance procedures will be the same for both coverage denials and other types of complaints. Some plans may have different procedures to handle different types of problems.

WHEN THE DIVISION OF INSURANCE CAN HELP YOU

If you have completed your health plan's review procedures and you are still not satisfied, you can contact the Colorado Division of Insurance. You are also welcome to contact the Division if you believe the health plan did not follow the time frames or requirements in this brochure.

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

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

or complete the complaint form on our website:

www.dora.state.co.us/insurance

It is important for you to complete your health plan's review process before contacting the Division of Insurance with your complaint. If you have not completed the review process, the Division will refer you back to your health plan.

The Division of Insurance can help you -

- Record your complaint against the health plan.
- Thoroughly investigate your complaint.
- Make sure the health plan follows state law.

The Division of Insurance cannot -

- Force a favorable utilization review decision.
- Require your plan to pay for services that are excluded by the policy.
- Provide legal services that are sometimes needed to settle complicated disputes.

TIPS FOR THE SAVVY CONSUMER

Read your policy or member handbook carefully. The key to getting quality health care is being an educated consumer. If you believe you have been wrongly denied coverage, create a paper trail by maintaining the following: your policy; copies of denial letters; copies of any correspondence between you and your health plan, or between your health care provider and your health plan; detailed notes of conversations with your health plan; and copies of correspondence with the Division.

In all correspondence to the Division, please include: your name, address, and telephone number; member ID number; policy number and type of policy.

For all telephone conversations, keep a written record of the date and time of your call, name of the person you spoke with, and what was discussed.

Send a copy of any letter to your employer's benefits manager. Your employer is interested in your satisfaction with the health plan. The benefits manager may have some leverage with the health plan, since employers can consider changing health plans if employees are not satisfied.

What Happens When Your Health Insurance Company Says No

Your Rights Regarding Insurance Pre-Authorization and Grievance Procedures

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