DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-65

CONCERNING THE ESTABLISHMENT OF A CARRIER PAYMENT ARBITRATION PROGRAM FOR OUT-OF-NETWORK PROVIDERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(15)(b), 10-16-704(18), and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements for a carrier payment dispute arbitration program; to ensure that out-of-network providers seeking arbitration concerning payment received from a carrier utilize a standard arbitration request form; and to establish qualification requirements for arbitrators who participate in this arbitration program.

Section 3 Applicability

This regulation applies to all carriers offering individual, small group and large group health benefit plans that will receive claims from out-of-network providers incurred on or after January 1, 2020 that are subject to the insurance laws of Colorado.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Commissioner” means, for the purposes of this regulation, the Commissioner of Insurance or his or her designee.

C. “Covered person” shall have the same meaning as found at § 10-16-102(15), C.R.S.

D. “De-identified” means, for the purposes of this regulation, the removal of all information that can be used to identify the patient from whose medical record the health information was derived.

E. “Out-of-network provider” means, for the purposes of this regulation, a provider in this state that has not entered into a contract with a carrier or with its contractor or subcontractor to provide health care services to covered persons.

F. “Payment” means, for the purposes of this regulation, the amount the carrier determines to be the total allowable charge for the covered services prior to the application of the managed care plan’s in-network deductible, coinsurance, and/or copayment requirements.

G. “Provider” shall have the same meaning as found at § 10-16-102(56), C.R.S.

H. “Qualified arbitrator” means, for the purposes of this regulation, an arbitrator who has submitted an application to the Commissioner for inclusion in the list of arbitrators maintained by the Division for the purposes of carrier payment arbitration program for out-of-network providers, and who has met the qualifications contained in Section 6 of this regulation and § 10-16-704(15)(b), C.R.S.

Section 5 Arbitration Process and Timelines

A. An out-of-network provider may request arbitration within ninety (90) calendar days of receipt of the payment, notice of payment, or remittance advice, as applicable, for a claim if the out-of-network provider:

1. Believes that the payment made by a carrier pursuant to §§ 10-16-704(3), 10-16-704 (5.5), or 25-3-122(3), C.R.S., as applicable, was not sufficient based upon the complexity and circumstances of the services provided; and

2. Sent a claim for a covered service to the carrier within one hundred eighty (180) calendar days after the receipt of insurance information, if required by § 25-3-122(3), C.R.S.

B. A request for arbitration is initiated when a request for arbitration has been filed by the out-of-network provider or facility with the Commissioner and the carrier using the form found in Appendix A of this regulation and is sent to a specific email address established by the carrier for this purpose.

C. The Commissioner shall appoint a qualified arbitrator within thirty (30) calendar days after the receipt of a request for arbitration by an out-of-network provider when an informal settlement teleconference has not been requested.

D. The out-of-network provider and the carrier may agree to participate in an informal settlement teleconference prior to the appointment of a qualified arbitrator. If the carrier does not agree to participate in a settlement teleconference, the out-of-network provider will notify the Division within three (3) business days of the carrier’s refusal to participate. If the carrier does agree to participate:

1. The informal settlement teleconference shall be held within thirty (30) calendar days of the request for arbitration;

2. The out-of-network provider and the carrier shall notify the Commissioner of the outcome of the informal settlement teleconference within five (5) business days of the conclusion of the teleconference and shall:

a. Advise whether or not the teleconference resulted in a settlement;

b. If a settlement was reached, provide the details of that settlement; and/or

c. If a settlement was not reached, request the appointment of an arbitrator.

3. After thirty (30) days, if the Division does not receive notice from either party regarding the result of the teleconference, an arbiter will be appointed.

E. The Commissioner shall appoint a qualified arbitrator within fifteen (15) calendar days of receiving notice that an informal settlement teleconference was unsuccessful.

F. Once the parties to the arbitration have been notified of the appointment of a qualified arbitrator by the Commissioner, each party to the arbitration must submit its final offer, and the reasoning for that offer in writing to the appointed arbitrator within thirty (30) calendar days of receipt of the notification. Any patient information submitted to the arbitrator in support of the offer being made shall be de-identified to ensure that protected health information is not disclosed.

G. If either the carrier or the out-of-network provider withdraws an arbitration request after an arbitrator has been assigned, the carrier, the out of network provider, and the arbitrator must agree to the withdrawal. If the arbitrator can demonstrate material work was initiated on the request, the party requesting the withdrawal must pay the arbitration fee to the assigned arbitrator.

H. If either the carrier or the out-of-network provider does not provide a final offer to the appointed arbitrator within the thirty (30) calendar days, the arbitrator must select the offer that has been received by the arbitrator.

I. If neither the carrier nor the out-of-network provider provide a final offer to the appointed arbitrator within the thirty (30) calendar days, the arbitration shall be considered complete, and the payment initially made to the out-of-network provider shall be considered to be payment in full by both parties.

J. If the carrier disagrees that the managed care plan under which the payment was made is subject to the requirements of § 10-16-704(15), C.R.S., or disagrees that the out-of-network provider complied with the requirements of Section 5.A.1., the carrier shall have two (2) business days to provide the Commissioner with the documentation to support its determination. If the Commissioner agrees, both parties and the arbitrator shall be advised of the termination of the arbitration process within two (2) business days of the receipt of the carrier's documentation.

K. The appointed arbitrator shall make its decision and notify the parties to the arbitration and the Commissioner, in writing, utilizing the form found in Appendix B of this regulation, within forty-five (45) calendar days after the date of the arbitrator's appointment. The arbitrator's decision and notification shall include a description of the reasoning for the arbitrator's decision.

L. The party whose final offer amount was not selected by the arbitrator shall pay the arbitrator's expenses and fees within thirty (30) calendar days of receiving an invoice from the arbitrator. If the provider responsible for paying for the arbitration after the decision has been made fails to pay for the arbitration when required, no further requests for arbitration will be accepted from that provider until any past-due payments have been resolved.

M. If the informal teleconference settlement or the arbitrator's decision requires the carrier to make an additional payment:

1. The carrier shall re-adjudicate the relevant claim(s) within thirty (30) calendar days of the informal teleconference settlement or the arbitrators decision or be subject to the payment of interest and penalties in accordance with § 10-16-106.5, C.R.S.; and

2. The carrier shall notify the covered person of any change to his or her deductible, coinsurance, and/or copayment calculations and provide information regarding the out-of-network provider's responsibility to refund any overpayment pursuant to §§ 12-30-113(2) and 25-3-122(2), C.R.S.

N. If the informal teleconference settlement or arbitrator's decision does not require the carrier to make an additional payment:

1. The carrier shall notify the covered person of the outcome of the arbitration and advise the covered person that the out-of-network provider is prohibited from billing the covered person directly except for the covered person's required deductible, coinsurance, and/or copayment obligations.

2. The carrier's notification shall also advise the covered person of the requirement for the out-of-network provider to reimburse him or her within sixty (60) calendar days after the date the out-of-network provider is notified by the carrier of an overpayment if the covered person has paid the out-of-network provider more than amounts due related to the covered person's deductible, coinsurance, and/or copayment for the covered service.

O. The arbitrator's decision is final and binding on both parties and only applies to the covered person's services identified in the arbitration request unless the parties agree otherwise.

P. Information submitted to the Division and/or an arbitrator appointed by the Commissioner pursuant to § 10-16-704(15), C.R.S., shall be considered confidential pursuant to § 24-72-204(3), C.R.S.

Section 6 Arbitrator Qualifications and Selection

A. The Division shall post a list of qualified arbitrators on its website.

B. In order for an arbitrator to apply for consideration for inclusion on the list of qualified arbitrators, the following qualifications must be met:

1. Provide evidence of having completed arbitration training by the American Arbitration Association or the American Health Lawyers Association, or a similar entity;

2. Demonstrate good standing with the state agency that licenses, registers or otherwise regulates attorneys in the states in which he or she practices;

3. Demonstrate experience in health care billing and health care reimbursement rates;

4. Demonstrate and certify that neither they nor their family members have a professional affiliation with any of the following:

a. A carrier or a professional association of carriers;

b. A health care facility or a professional association of health care facilities; or

c. Health care providers or a professional association of health care providers;

5. Provide a schedule of expenses and fees to be used for arbitrations; and

6. Agree to comply with the requirements of § 10-16-704(15) C.R.S.

C. The Commissioner shall randomly select a qualified arbitrator to conduct an initiated arbitration from the list of qualified arbitrators maintained by the Division. If the selected arbitrator is currently involved in an ongoing arbitration, another arbitrator shall be selected by the Commissioner.

D. Once a qualified arbitrator has been selected, the Division will contact the arbitrator and identify the parties involved in the request for arbitration. Prior to finalizing the appointment to conduct the arbitration, the arbitrator must attest to the Commissioner that they or a family member do not have:

1. A personal conflict of interest with any parties to the arbitration;

2. Any professional conflict of interest with any parties to the arbitration; nor

3. A financial conflict of interest with any parties to the arbitration.

If any conflicts of interest exist between the arbitrator and the parties to the arbitration, the arbitrator shall disclose those conflicts of interest to the Commissioner within three (3) business days of being contacted by the Commissioner to oversee an arbitration, and another qualified arbitrator shall be selected.

E. The qualified arbitrator shall demonstrate that there are no conflicts of interest in the arbitration by submitting an attestation to the Commissioner. Once the attestation has been received by the Commissioner and reviewed, the Commissioner will provide final approval of the appointment to the arbitrator, and notify the parties that the arbitration can begin.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective March 30, 2025.

Section 10 History

Emergency regulation effective December 20, 2019.
Regulation effective April 15, 2020.
Regulation effective March 30, 2025.

Appendix A

COLORADO
Department of Regulatory Agencies
Division of Insurance

Division of Insurance Out-of-Network Provider Arbitration Request Form

Date of Request: (Must be within ninety (90) calendar days after receipt of the payment, notice of payment, or remittance advice.)	Patient's plan is regulated by the Division: *(See information on back.)* Yes ☐ No ☐ **If "no", do not submit this request.**	
Name and Contact Information of Provider or Facility Requesting Arbitration:		
The Entity Requesting Arbitration is a:	Out-of-Network Health Care Facility ☐	License Type:
	Out-of-Network Health Care Provider ☐	Specialty Type:
Description of Health Care Services Provided (including any applicable CPT codes):		
Group/Plan #:		
Claim Number(s):		
Date(s) of Service:		
Amount billed by Out-of-Network Health Care Provider or Out-of-Network Facility:	Carrier-determined Eligible Amount for Covered Services:	Date payment, notice of payment, or remittance advice received: *(Attach a copy of the notice to this form.)*
Name and Contact Information of Carrier Identified for Arbitration:		
I will be initiating an informal settlement teleconference with the carrier	Yes ☐	

prior to initiation of the arbitration process and I will notify the Division within three (3) business days if the carrier declines my request for a settlement teleconference.	No ☐

Please review important information on the back of this form prior to submitting this request.

1. Only claim payments made in connection with health insurance plans regulated by the Division of Insurance have access to the arbitration process. Examples of health insurance plans that are not included are:

    - Medicare and Medicaid
    - Federal employee benefit plans
    - Plans issued to employers headquartered in another state
    - Plans which are self-funded by employers under ERISA

    Please check for a “CO-DOI” notification listed on the patient’s ID card prior to submitting this request as it means this plan is regulated by the Division.

2. The out-of-network emergency services facility and/or out-of-network provider providing emergency services or services at an in-network facility may submit this request if it is believed that the payment made for the covered services was not sufficient given the complexity and circumstances of the services provided to the patient.

3. If the facility/provider and the carrier agree to participate in an informal settlement teleconference prior to the start of arbitration, it will be scheduled and must be completed within thirty (30) calendar days of this request.

4. If no informal settlement teleconference has been agreed to, both the facility/provider and carrier will be provided with the contact information for the appointed arbitrator. Both parties will have thirty (30) calendar days to submit their final offer and their argument supporting the final offer in writing given the complexity and circumstance of the services provided to the patient.

5. The arbitrator will issue a written decision to both parties within forty-five (45) calendar days of appointment, choosing the facility’s, the provider’s or the carrier’s final offer. This decision is final and binding on both parties and only applies to the services (claims) identified in the arbitration request unless the parties agree otherwise.

6. The party whose final offer amount was not selected shall pay the arbitrator’s expenses and fees within thirty (30) calendar days of receipt of the invoice.

Appendix B

COLORADO
Department of Regulatory Agencies
Division of Insurance

Division of Insurance Arbitration Decision and Reporting Form

Upon decision, a copy of this form is to be sent by the Arbitrator to the Carrier, the requesting Out-of-Network Provider/Facility and the Division of Insurance	
Arbitrator Name:	Division's Arbitration Tracking Number:
Date of Arbitrator Appointment:	Date of Arbitration Decision:
Is additional payment being requested because the out-of-network provider/facility believes that the amount allowed for the covered services was not sufficient given the ***complexity and circumstances of the services provided to the patient***? ☐ YES ☐ NO	
Decision Found for: ☐ Out-of-Network Health Care Facility ☐ Out-of-Network Health Care Provider ☐ Carrier	
The decision was reached through: ☐ Arbitrator's decision ☐ Closed due to lack of communication from the parties involved	
Provider/Facility Name:	Carrier Name:
Provider Specialty:	
Facility License Type:	
Date(s) of Service for Arbitrated Claim:	
Claim Number(s):	
Initial Carrier-determined Allowable Amount for Covered Services:	
Amount billed by Out-of-Network Provider or Facility:	
Final Offer of Carrier for Allowable Amount for Covered Services:	
Date Received:	
Reason(s) Provided by Carrier for Final Offer's Allowable Amount:	

Final Offer Requested by Out-of-Network Provider/Facility:	
Date Received:	
Reason(s) Provided by Out-of-Network Provider or Facility for Final Allowable Amount Requested:	
Arbitrator's Decision	
Final Allowable Amount :	
Reason(s) for Arbitrator's Decision:	
Fee charged in accordance with arbitrator's filed fee schedule and basis used for fee determination:	

Name and Contact Information of Arbitrator:
I certify that I have no personal or professional conflict of interest with either party involved in this arbitration. Signature Date
The Arbitrator's fee must be paid within thirty (30) calendar days by the: Carrier ☐ Provider/Facility ☐

Important Information for the Carrier

The carrier shall notify the covered person of any change to his or her deductible, coinsurance, and/or copayment calculations and provide information regarding the out-of-network provider's responsibility to refund any overpayment pursuant to §§ 12-30-113(2)(a) and 25-3-122(2), C.R.S.

The carrier shall notify the covered person of the outcome of the arbitration and advise the covered person that the out-of-network provider is prohibited from billing the covered person directly except for the covered person's required in-network deductible, coinsurance, and/or copayment obligations.

The carrier's notification shall also advise the covered person of the requirement for the out-of-network provider to reimburse him or her within sixty (60) calendar days after the date the out-of-network provider is notified by the carrier of an overpayment if the covered person has paid the out-of-network provider more than amounts due related to the covered person's deductible, coinsurance, and/or copayment for the covered service(s).

Important Information for the Provider/Facility

Providers and facilities shall not bill or collect a payment from the covered person for any outstanding balance for covered services not paid by the carrier except for the applicable in-network deductible, coinsurance, or copayment amount required to be paid by the covered person.

If the provider or facility received a payment from the covered person for amounts the covered person is not responsible for pursuant to § 10-16-704(3)(b) or (5.5), C.R.S., or due to an additional payment made by the carrier as a result of this arbitration, it shall reimburse the covered person within sixty (60) calendar days after the date the overpayment is reported to it.

A provider or facility that fails to reimburse a covered person as required by §§ 12-30-113(2) or 25-3-122(2)(a), C.R.S., shall pay interest on the overpayment as required by §§ 12-30-113(2)(b) or 25-3-122(2)(b), C.R.S.