DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

DRAFT Proposed Amended Regulation 4-2-17

PROMPT INVESTIGATION OF HEALTH CLAIMS INVOLVING UTILIZATION REVIEW AND DENIAL OF BENEFITS AND RULES RELATED TO INTERNAL CLAIMS AND APPEALS PROCESSES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110, 10-16-109, 10-16-112.5 and 10-16-113(2) and (10), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of §§ 10-3-1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving utilization review and certain denials of benefits for treatment, as well as rescission, cancellation, or denial of coverage based on an eligibility determination, as described herein. Among other things, § 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from health coverage plans; promptly provide a reasonable explanation of the basis in the health coverage plan in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information.

This regulation is designed to provide minimum standards for handling appeals and grievances involving utilization review determinations, certain denials of benefits for treatments excluded by health coverage plans, and as otherwise required by § 10-16-113, C.R.S.

Requirements regarding prior authorization for prescription drugs are found in Colorado Insurance Regulation 4-2-49. Prior authorization reporting requirements are found in Colorado Insurance Regulation 4-2-101.

Section 3 Applicability

The provisions of this regulation shall apply to all health coverage plans, including, but not limited to, dental insurance policies. It does not apply to long-term care insurance policies as the requirements for the appeals process for that type of health coverage plan is covered under a separate regulation. This regulation shall not apply to automobile medical payment policies, worker's compensation policies, or property and casualty insurance. Where a decision concerning a claim is not based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation. However, this regulation shall apply to a carrier's denial of a benefit because the treatment is excluded by the health coverage plan if the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

Solely with respect to the requirements in sections 7.F.2. and 8.F.2., this regulation does not apply to a health maintenance organization which provides a majority of covered professional services through a single contracted medical group or to a nonprofit health maintenance organization operated by or under the control of the Denver Health and Hospital Authority created by Article 29 of Title 25 or any of its subsidiaries.

Section 4 Definitions

A. "Adverse determination" means, for the purposes of this regulation:

1. A determination by a carrier or its designee that a request for a prospective or retrospective benefit has been reviewed and, based upon the information provided, does not meet the carrier's requirement for medical necessity, or that the benefit is not appropriate, effective, efficient, is not provided in or at the appropriate health care setting or level of care, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated;

2. A denial for a benefit excluded by a health coverage plan for which the covered person is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit;

3. A rescission or cancellation of coverage applied retroactively that is not attributed to a failure to pay premiums. However, a physician is not required to evaluate an appeal of this type of adverse determination; and

4. A denial of coverage to an individual based on an initial eligibility determination for all:

   a. Individual sickness and accident insurance policies issued by a carrier subject to Part 2 of Article 16 of Title 10; and

   b. Individual health care or indemnity contracts issued by a carrier subject to Parts 3 or 4 of Article 16 of Title 10.

Section 4.A.4. does not apply to supplemental policies covering a specified disease or other limited benefit. A physician is not required to evaluate an appeal of this type of adverse determination.

B. "Ambulatory review" means, for the purposes of this regulation, a utilization review of health care services performed or provided in an outpatient setting.

C. "Applicable non-English language" means, for the purposes of this regulation, with respect to an address in any Colorado county to which a notice is sent, a non-English language that ten percent (10%) or more of the population residing in the county is only literate in as determined by the Secretary of the United States Department of Health and Human Services.

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

E. "Carrier's receipt" means, for the purposes of this regulation, the receipt date as date-stamped by the carrier in a legible manner; an electronically-formatted receipt date; a facsimile transmission date; or a receipt date imprinted on the document in some type of permanent manner. The earliest receipt date on the document will be considered the carrier's receipt date.

F. "Case management" means, for the purposes of this regulation, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

G. "Clinical peer" means, for the purposes of this regulation, a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

H. "Complaint" means, for the purposes of this regulation, a written communication primarily expressing a grievance.

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

J. "Date of receipt of a notice" means, for the purposes of this regulation, the date that shall be calculated to be no less than three (3) calendar days after the date the notice is postmarked by the carrier.

K. "Designated representative" means, for the purposes of this regulation:

1. A person, including the treating health care professional or a person authorized by subsection 4.K.2., to whom a covered person has given express written consent to represent the covered person;

2. A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, a proxy, or a designee of the Colorado Department of Health Care Policy and Financing; and/or

3. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

L. "Disability" means, for the purposes of this regulation, with respect to a covered person, a physical or mental impairment that substantially limits one or more of the major life activities of such covered person, in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101.

M. “Discharge planning” means, for the purposes of this regulation, the formal process for determining, prior to discharge from a medical facility or service, the coordination and management of the care that a covered person receives following discharge from a medical facility or service.

N. “Emergency medical condition” means, for the purposes of this regulation, the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the covered person’s health in serious jeopardy.

O. “Grievance” means, for the purposes of this regulation, a circumstance regarded as a cause for protest, including the protest of an adverse determination.

P. “Health care professional” means, for the purposes of this regulation, a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

Q. “Health care services” shall have the same meaning as found at § 10-16-102(33), C.R.S.

R. “Health coverage plan” shall have the same meaning as found at § 10-16-102(34), C.R.S.

S. “Life or limb threatening emergency” means, for the purposes of this regulation, any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

T. “Managed care plan” shall have the same meaning as found at § 10-16-102(43), C.R.S.

U. “Medical facility” means, for the purposes of this regulation, an institution providing health care services, or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

V. “Medical professional” means, for the purposes of this regulation, an individual licensed pursuant to the “Colorado Medical Practice Act”, article 240 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the “Dental Practice Law of Colorado”, article 220 of title 12, C.R.S., acting within his or her scope of practice.

W. “Notice of the adverse determination” and “notice of the initial adverse determination”, for the purposes of this regulation, do not include an explanation of benefits (EOB) form.

X. “Prior authorization” shall have the same meaning as found at § 10-16-112.5(7)(d), C.R.S.

Y. “Prospective review” and “prospective utilization review” mean, for the purposes of this regulation, a utilization review conducted prior to an admission or course of treatment requested by a covered person, designated representative, medical facility, or health care professional. It does not include prior authorizations required by a carrier.

Z. “Rescission” means, for the purposes of this regulation, the cancellation or discontinuance of coverage that has a retroactive effect. This includes a cancellation that treats a policy as void from the time of enrollment and a cancellation that voids benefits paid up to a year before the cancellation takes place. A rescission of coverage shall be treated as an adverse determination. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is exclusively prospective, or the cancellation or discontinuance is retroactive only

to the extent attributable to a failure to pay premiums or contributions toward the cost of coverage in a timely manner.

AA. “Retrospective review” and “retrospective utilization review” mean, for the purposes of this regulation, utilization review conducted after services have been provided to a covered person, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

AB. “Second opinion” means, for the purposes of this regulation, an opportunity or requirement to obtain a clinical evaluation by a health care professional other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the proposed health care service.

AC. “Voluntary second level review” means, for the purposes of this regulation, a request for a review of an adverse determination from a first-level appeal which is only available to persons covered under a group health coverage plan.

AD. “Stabilized” means, for the purposes of this regulation, with respect to an emergency medical condition or a life or limb threatening emergency, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.

AE. “Urgent care request” means, for the purposes of this regulation:

1. A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination that:

    a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or for a covered person with a physical or mental disability, creates an imminent and substantial limitation on his or her existing ability to live independently; or

    b. In the opinion of a health care professional with knowledge of the covered person’s medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

2. Except as provided in section 4.AE.3., in determining whether a request is to be treated as an urgent care request, a person acting on behalf of the carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

3. Any request that a health care professional with knowledge of the covered person’s medical condition determines and states is an urgent care request within the meaning of section 4.AE.1. shall be treated as an urgent care request.

AF. “Utilization review” means, for the purposes of this regulation, a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, authorization, concurrent review, case management, discharge planning, and retrospective review. It also includes reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5 Compliance Requirements

A. Pursuant to § 10-3-1104(1)(h)(IV), C.R.S., a carrier that does not use a procedure for investigating claims involving utilization review consistent with this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information.

B. Pursuant to § 10-3-1104(1)(h)(III), C.R.S., a carrier using standards in the review of claims involving utilization review that are not in compliance with the rules contained in this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier use reasonable standards for the prompt investigation of claims.

C. Pursuant to § 10-3-1104(1)(h)(II), C.R.S., a carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims.

D. Pursuant to § 10-3-1104(1)(h)(XIV), C.R.S., a carrier that does not follow the procedures for explaining the basis of a utilization review decision set forth in this regulation shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim.

E. Pursuant to § 10-3-1104(1)(h)(IV), C.R.S., a carrier that does not allow an appeal, consistent with the procedures set forth in this regulation, of a benefit denial for a treatment excluded by the health coverage plan when the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply shall be deemed to be in violation of the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information.

F. Carriers shall avoid conflicts of interest to ensure all benefit reviews and appeals are adjudicated in a manner designed to guarantee the independence and impartiality of the persons involved in making the decision. With respect to any person involved in the review of benefit requests and/or the review of appeals, decisions regarding hiring, compensation, termination, or promotion shall not be made based upon the likelihood that the person will support the denial of benefits.

Section 6 Form and Manner of Notices

A. Carriers shall provide all relevant notices in a culturally and linguistically appropriate manner as follows:

1. In the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier; and

2. Shall provide, upon request, a notice in any applicable non-English language and shall allow the covered person the option of electing to receive all subsequent notices in the requested applicable non-English language.

B. Carriers shall provide oral language services in any applicable non-English language, providing assistance with answering questions about the filing of benefit requests and appeals.

C. Solely for the purposes of the requirements of section 6.A.2., the term “notice” does not include a carrier’s explanation of benefits form.

Section 7 Standard Utilization Reviews - Prospective and Retrospective Reviews and Non-Urgent Prior Authorizations

A. A carrier shall establish written procedures in compliance with all of the requirements of this section for:

1. Reviewing prospective benefit requests received from a covered person, medical facility or a health care professional; and

2. Making and notifying the covered person, medical facility or the health care professional, as applicable, of utilization review decisions with respect to non-urgent benefit requests.

B. Prospective utilization review determinations.

1. Time period for determination and notification.

a. Subject to section 7.B.1.b., a carrier shall make the determination and notify the covered person and the covered person’s medical facility or health care professional of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person’s medical condition, but in no event later than fifteen (15) calendar days after the carrier’s receipt of the request. Whenever the determination is an adverse determination, the carrier shall make the notification of the adverse determination in accordance with section 7.E.

b. The time period for making a determination and notifying the covered person of the determination pursuant to section 7.B.1.a. may be extended one (1) time by the carrier for up to fifteen (15) calendar days, provided the carrier:

(1) Determines that an extension is necessary due to matters beyond the carrier’s control; and

(2) Notifies the covered person, prior to the expiration of the initial fifteen (15) calendar day time period, of the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.

c. If the extension under section 7.B.1.b. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

(1) Specifically describe the required information necessary to complete the request; and

(2) Give the covered person at least forty-five (45) calendar days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline will be extended to the next business day.

d. All coverage determinations shall include:

(1) A review of the covered person’s eligibility; and

(2) A review of the applicability of the health coverage plan's benefits, limitations and exclusions.

e. The authorization notice shall state that the service(s) and treatment(s) which are the subject of the standard utilization review request are covered services, subject to all of the terms and conditions of the policy, as long as:

(1) The covered person is still covered by the health coverage plan at the time the service(s) and treatment(s) are provided;

(2) The health care professional(s) and medical facility(ies) performing the authorized services are part of the carrier's network at the time of service unless otherwise specifically authorized; and

(3) Benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s) have not been exhausted.

f. Carriers may include beginning/end dates or the length of time the authorization is effective appropriate to the type of service being pre-authorized provided that they do not unnecessarily restrict the covered person's ability to schedule the services.

2. Failure to meet the carrier's filing procedures.

a. Whenever the carrier receives a prospective review request from a covered person that fails to meet the carrier's filing procedures, the carrier shall notify the covered person of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

b. Required notice.

(1) The notice required under section 7.B.2.a. shall be provided as soon as possible, but in no event later than five (5) calendar days following the date of the failure.

(2) The carrier shall provide the notice in writing.

c. The provisions of section 7.B.2. shall apply only in the case of a failure that:

(1) Is a communication by a covered person that is received by a person or organizational unit of the carrier responsible for handling benefit matters; and

(2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or medical facility and/or health care professional for which authorization is being requested.

3. For an adverse determination regarding a prospective review decision that occurs during a covered person's hospital stay or course of treatment, also known as concurrent review, the health care service or treatment that is the subject of an adverse determination shall continue to be covered according to the provisions of the health coverage plan until the covered person has been notified of the determination by the carrier.

4. The requirements of section 7.B. apply to all written requests involving utilization review received by the carrier which are submitted by a covered person or a medical facility and/or health care professional requesting a determination of coverage for a specific health care service or treatment for the covered person.

C. Retrospective utilization review determinations.

1. For retrospective utilization review determinations, a carrier shall make the determination and notify the covered person and the covered person's medical facility and/or health care professional of the determination within a reasonable period of time, but in no event later than thirty (30) calendar days after the carrier's receipt of the benefit request. Whenever the determination is an adverse determination, the carrier shall provide notice of the adverse determination to the covered person in accordance with section 7.E.

2. Time period for determination and notification.

a. The time period for making a determination and notifying the covered person of the determination pursuant to section 7.C.1. may be extended one (1) time by the carrier for up to fifteen (15) calendar days, provided the carrier:

(1) Determines that an extension is necessary due to matters beyond the carrier's control; and

(2) Notifies the covered person, prior to the expiration of the initial thirty (30) calendar day time period, of the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.

b. If the extension under section 7.C.2.a. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

(1) Specifically describe the required information necessary to complete the request; and

(2) Give the covered person at least forty-five (45) calendar days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.

D. Calculation of time periods.

1. For purposes of calculating the time periods within which a determination is required to be made under sections 7.B. and 7.C., the time period shall begin on the date of the carrier's receipt of the request in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

2. Extensions.

a. If the time period for making the determination under sections 7.B. or 7.C. is extended due to the covered person's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the carrier sends the notification of the extension to the covered person until the earlier of:

(1) The date on which the covered person responds to the request for additional information; or

(2) The date on which the specified information was to have been submitted.

b. If the covered person fails to submit the information before the end of the period of the extension, as specified in sections 7.B. or 7.C., the carrier may deny the authorization of the requested benefit.

E. Requirements for adverse determination notifications.

1. Except for the adverse determinations described section 7.E.2., a notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

a. An explanation of the specific medical basis for the adverse determination;

b. The specific reason or reasons for the adverse determination;

c. Reference to the specific plan provisions on which the determination is based;

d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

e. If the carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. Information sufficient for the covered person to be able to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

h. If applicable, instructions for requesting:

(1) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 7.E.1.e.;

(2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in section 7.E.1.f.; and/or

(3) The information necessary to identify the claim, as provided in section 7.E.1.g.;

i. A description of the carrier's review procedures and the time limits applicable to such procedures; and

j. An explanation of the right of the covered person to appeal an initial adverse determination with a description of the procedures for requesting an appeal.

(1) For individual health coverage plans, the notice shall include:

(a) An explanation of the right to a single level of internal appeal through a written appeal review or, unless it is an expedited appeal, the ability to appear in person or by telephone conference at a review meeting; and

(b) A description of the process to schedule a review meeting including the covered person's rights pursuant to section 12.

(2) For group health coverage plans, the notice shall advise that the covered person does not have the right to be present during the first level review.

2. For denials based on a contractual exclusion, the adverse determination notice shall include the health coverage plan's specific exclusion language and shall advise the covered person of the right to appeal the applicability of the exclusion by providing evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply.

3. A carrier shall provide the notice required under this section in writing, either on paper or electronically.

4. All written adverse determinations, except an adverse determination described in § 10-16-113(1)(b)(I)(C) and (E), C.R.S., shall be reviewed and signed by a licensed physician familiar with standards of care in Colorado. The physician is not required to be identified by name and may only include the physician's licensure number. In the case of written denials of requests for covered benefits for dental care, a licensed dentist familiar with standards of care in Colorado may review and sign the written denial. Initial adverse determination notifications provided on an explanation of benefits form (EOB) are exempt from this requirement.

5. The notice of the initial adverse determination shall include information concerning the covered person's ability to request an internal and external expedited review on a concurrent basis. This information may be included in the letter or other notice advising the covered person of the finding of an adverse determination, or it may be included as a separate document within the same mailing.

F. ~~Applicability.~~ Carrier Requirements for Non-Urgent Prior Authorization Requests

1. The requirements of section 7 apply to all written requests involving standard utilization prospective reviews received by the carrier which are submitted by covered person, designated representative, a medical facility, and/or a health care professional requesting a determination of coverage for a specific health care service or treatment for the covered person.

2. Carriers' Requirements ~~for Non-Urgent Prior Authorization Requests~~.

a. Time period for determination and notification.

(1) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person within five (5) business days after the carrier's receipt of the request, that the request is approved, denied, or incomplete.

(2) If the request is incomplete, the carrier shall indicate the specific additional information consistent with the requirements of §§ 10-16-112.5(2)(a) and 10-16-112.5(4)(a)(III), C.R.S., required to process the request.

(a) The medical facility or health care professional, as applicable, shall submit the additional information within two (2) business days after receipt of the request for additional information. If the medical facility or health care professional, as applicable, fails to submit the required additional information, the prior authorization is not deemed granted.

(b) If additional information pursuant to the requirements of § 10-16-112.5(4)(a)(III), C.R.S., is required from the covered person, carriers shall give him or her at least forty-five (45) calendar days from the date of receipt of the notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline will be extended to the next business day.

(i) Carriers shall notify the medical facility or health care professional, as applicable, that the covered person has additional time to submit the required information.

(ii) The prior authorization request will not be deemed as granted during this time period.

(3) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person that the request is approved or denied within five (5) business days after the carrier's receipt of the additional information required pursuant to section 7. F.2.a.(2) or the end of time period specified in section 7.F.2.a.(2)(b).

(4) The prior authorization request is deemed granted if a carrier fails to provide the notification as required by section 7.F.2.a.(1). except as provided in section 7.F.2.a.(2)(b). Carriers shall assign a unique authorization number to be utilized by the medical facility or health care professional, as applicable, for claim submission for a prior authorization that is deemed granted pursuant to this Section 7.F.2.a.(4).

b. Approval of the prior authorization request.

(1) All approvals shall include:

(a) A review of the covered person's eligibility; and

(b) A review of the applicability of the health coverage plan's benefits, limitations and exclusions; and

(c) A unique prior authorization number attributable to the request.

(2) The approval shall state that the service(s) and treatment(s) which are the subject of the prior approval request are covered services as long as the covered person is still covered by the same health coverage plan at the time the service(s) and treatment(s) are provided and shall include applicable requirements, if any, to use contracted medical facilities and health care professionals unless otherwise specifically authorized. The notice shall also reference any benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s).

(3) For health benefit plans, the approval for a surgical procedure shall include additional or related health care procedures identified during the procedure so long as all criteria set forth in § 10-16-112.5(4)(c)(I) C.R.S. are met, unless an exception in § 10-16-112.5(4)(c)(I), C.R.S. applies.

c. Denial of the prior authorization request.

(1) If the carrier denies the prior authorization request, it shall comply with the requirements of section 7.E. as applicable;

(2) The carrier shall include information concerning any alternative services, treatment, test, procedure, or medication it requires and, for health benefit plans, what alternative services or treatments may be a covered benefit; and

(3) The carrier shall assign and provide a unique prior authorization number attributable to the request as required by § 10-16-112.5(3)(c)(I), C.R.S.

(4) Section 7.F.2.c.(2) applies to prior authorization requests for drug benefits subject to § 10-16-124.5, C.R.S.

d. Upon approval, a prior authorization is valid for at least ~~180 days~~one (1) year from ~~after~~ the date of approval and continues for the duration of the authorized course of treatment unless:

(1) The prior authorization approval was based on fraud;

(2) The medical facility or health care professional, as applicable, never performed the services that were requested;

(3) The service provided did not align with the service that was authorized;

(4) The person receiving the service is no longer covered by the health coverage plan on or before the date the service was delivered; or

(5) The covered person's benefit maximums were reached on or before the date the service was delivered.

e. A change in a carrier's coverage or approval criteria for a previously approved health care service does not affect a covered person who received a prior authorization before the effective date of the change for the remainder of the covered person's plan year.

Section 8 Expedited Utilization Reviews- Prospective and Retrospective Reviews and Urgent Prior Authorization Requests

A. Procedures.

1. A carrier shall establish written procedures in compliance with all of the requirements of this section for:

   a. Reviewing prospective urgent care benefit requests received from a covered person, medical facility or a health care professional; and

   b. Making and notifying the covered person, medical facility or the health care professional, as applicable, of expedited utilization review decisions with respect to urgent care benefit requests.

For the purposes of Section 8, "covered person" includes the designated representative of a covered person.

2. Notification requirements.

   a. As part of the procedures required under section 8.A.1., a carrier shall provide that, in the case of a failure by a covered person to follow the carrier's procedures for filing an urgent care request, the covered person shall be notified of the failure and the proper procedures to be followed for filing the request.

   b. The notice required under section 8.A.2.a.:

      (1) Shall be provided to the covered person as soon as possible but not later than twenty-four (24) hours after the carrier's receipt of the request; and

      (2) Shall be in writing.

   c. The provisions of section 8.A.2. apply only in the case of a failure that:

      (1) Is a communication by a covered person that is received by a person or organizational unit of the carrier responsible for handling benefit matters; and

      (2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or medical facility and/or health care professional for which approval is being requested.

B. Urgent care requests.

1. Notification requirements for carrier determinations.

   a. For an urgent care request, unless the covered person has failed to provide sufficient information for the carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the covered person's health coverage plan, the carrier shall notify the covered person and the covered person's medical facility and health care professional of the carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the carrier's receipt of the request.

b. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with section 8.E.

c. All coverage determinations shall include:

(1) A review of the covered person's eligibility; and

(2) A review of the applicability of the health coverage plan's benefits, limitations and exclusions.

d. The authorization notice shall state that the service(s) and treatment(s) which are the subject of the urgent utilization review request are covered services, subject to all of the terms and conditions of the policy, as long as:

(1) The covered person is still covered by the health coverage plan at the time the service(s) and treatment(s) are provided;

(2) The health care professional(s) and medical facility(ies) performing the authorized services are part of the carrier's network at the time of service unless otherwise specifically authorized; and

(3) Benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s) have not been exhausted.

e. Carriers may include beginning/end dates or the length of time the authorization is effective appropriate to the type of service or treatment being pre-authorized provided that they do not unnecessarily restrict the covered person's ability to schedule the services.

2. Notification requirements for insufficient information.

a. If the covered person fails to provide sufficient information for the carrier to make a determination, the carrier shall notify the covered person either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after the carrier's receipt of the request.

b. The carrier shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person of the failure to submit sufficient information, as provided in section 8.B.2.a.

c. The carrier shall notify the covered person and the covered person's medical facility and health care professional of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:

(1) The carrier's receipt of the requested specified information; or

(2) The end of the period provided for the covered person to submit the requested specified information.

d. If the covered person fails to submit the information before the end of the period of the extension, as specified in section 8.B.2.b., the carrier may deny the authorization of the requested benefit.

e. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with section 8.E.

C. Concurrent urgent care review requests.

1. For concurrent urgent care review requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments authorized, if the request is made at least twenty-four (24) hours prior to the expiration of the authorized period of time or authorized number of treatments, the carrier shall make a determination with respect to the request and notify the covered person and the covered person's medical facility or health care professional of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the carrier's receipt of the request.

2. If the carrier's determination is an adverse determination, the carrier shall provide notice of the adverse determination in accordance with section 8.E. The health care service or treatment that is the subject of an adverse determination shall continue to be covered according to the provisions of the health coverage plan until the covered person has been notified of the determination by the carrier.

D. For purposes of calculating the time periods within which a determination is required to be made under sections 8.B. or 8.C., the time period shall begin on the date of the carrier's receipt of the request in accordance with the carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

E. Adverse determination notification requirements.

1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

a. An explanation of the specific medical basis for the adverse determination;

b. The specific reasons or reasons for the adverse determination;

c. Reference to the specific plan provisions on which the determination is based;

d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary;

e. If the carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity, experimental or investigational treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the

terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. Information sufficient for the covered person to be able to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

h. If applicable, instructions for requesting:

(1) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 8.E.1.e.;

(2) The written statement of the scientific or clinical rationale for the adverse determination, as provided in section 8.E.1.f.; and/or

(3) The information necessary to identify the claim, as provided in section 8.E.1.g.;

i. A description of the carrier's expedited review procedures and the time limits applicable to such procedures; and

j. An explanation of the right of the covered person to appeal an initial adverse determination with a description of the procedures for requesting an appeal.

(1) For individual health coverage plans, the notice shall include an explanation of the right to a single level of internal appeal through a written appeal review and, because it is an expedited appeal, the inability to appear in person or by telephone conference at a review meeting.

(2) For group health coverage plans, the notice shall advise that the covered person does not have the right to be present during the first level review.

2. Additional notification requirements.

a. A carrier may provide the notice required under this section orally, in writing, or electronically.

b. If notice of the adverse determination is provided orally, the carrier shall provide a written or electronic notice of the adverse determination within three (3) calendar days following the oral notification.

3. All written adverse determinations shall be reviewed and signed by a licensed physician familiar with standards of care in Colorado. The physician is not required to be identified by name and may only include the physician's licensure number. In the case of written denials of requests for covered benefits for dental care, a licensed dentist familiar with standards of care in Colorado may review and sign the written denial.

4. The notice of the initial adverse determination shall include information concerning the covered person's ability to request an internal and external expedited review on a concurrent basis. This information may be included in the letter or other notice advising the covered person of the finding of an adverse determination, or it may be included as a separate document within the same mailing.

F. ~~Applicability.~~ Carriers' Requirements for Urgent Prior Authorization Requests

1. The requirements of section 8 apply to all written requests involving expedited utilization prospective reviews received by the carrier which are submitted by a covered person, designated representative, a medical facility, or a health care professional requesting a determination of coverage for a specific health care service or treatment for the covered person.

2. Carriers' Requirements ~~for Urgent Prior Authorization Requests~~.

a. Time period for determination and notification.

(1) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person within two (2) business days but not longer than seventy-two (72) hours after the carrier's receipt of the request, that the request is approved, denied, or incomplete.

(2) If the request is incomplete, the carrier shall indicate the specific additional information consistent with the requirements of §§ 10-16-112.5(2)(a) and 10-16-112.5(4)(a)(III), C.R.S., required to process the request.

(a) The medical facility or health care professional, as applicable, shall submit the additional information within two (2) business days after receipt of the request for additional information. If the medical facility or health care professional, as applicable, fails to submit the required additional information, the prior authorization is not deemed granted.

(b) If additional information pursuant with the requirements of § 10-16-112.5(4)(a)(III), C.R.S., is required from the covered person, carriers shall give him or her at least forty-eight (48) hours from the date of receipt of the notice to provide the specified information.

(i) Carriers shall notify the medical facility or health care professional, as applicable, that the covered person has additional time to submit the required information.

(ii) The prior authorization request will not be deemed as granted during this time period.

(3) Carriers shall notify the medical facility or health care professional, as applicable, and the covered person that the request is approved or denied within forty-eight (48) hours after the carrier's receipt of the additional information required pursuant to section 8.F.2.a.(2) or the end of time period specified in section 8.F.2.a.(2)(b).

(4) The prior authorization request is deemed granted if a carrier fails to provide the notification as required by section 8.F.2.a.(1) except as provided in section 8.F.2.a.(2)(b). Carriers shall assign a unique authorization number to be utilized by the medical facility or health care professional, as applicable, for claim submission for a prior authorization that is deemed granted pursuant to this Section 8.F.2.a.(4).

b. Approval of the prior authorization request.

(1) All approvals shall include:

(a) A review of the covered person's eligibility;

(b) A review of the applicability of the health coverage plan's benefits, limitations and exclusions; and

(c) A unique prior authorization number attributable to the request.

(2) The approval shall state that the service(s) and treatment(s) which are the subject of the prior approval request are covered services as long as the covered person is still covered by the same health coverage plan at the time the service(s) and treatment(s) are provided and shall include applicable requirements, if any, to use contracted medical facilities and health care professionals unless otherwise specifically authorized. The notice shall also reference any benefit limitations, such as annual visit or monetary limitations, which may apply to the approved service(s) and treatment(s).

(3) For health benefit plans, the approval for a surgical procedure shall include additional or related health care procedures identified during the procedure so long as all criteria set forth in § 10-16-112.5(4)(c)(I) C.R.S. are met, unless an exception in § 10-16-112.5(4)(c)(I), C.R.S. applies.

c. Denial of the prior authorization request.

(1) If the carrier denies the prior authorization request, it shall comply with the requirements of section 8.E. as applicable;

(2) The carrier shall include information concerning any alternative services, treatment, test, procedure, or medication it requires and, for health benefit plans, what alternative services or treatments may be a covered benefit; and

(3) The carrier shall assign and provide a unique prior authorization number attributable to the request as required by § 10-16-112.5(3)(c)(I), C.R.S.

(4) Section 8.F.2.c.(2) applies to prior authorization requests for drug benefits subject to § 10-16-124.5, C.R.S.

d. Upon approval, a prior authorization is valid for at least 180 days after the date of approval and continues for the duration of the authorized course of treatment unless:

(1) The prior authorization approval was based on fraud;

(2) The medical facility or health care professional, as applicable, never performed the services that were requested;

(3) The service provided did not align with the service that was authorized;

(4) The person receiving the service is no longer covered by the health coverage plan on or before the date the service was delivered; or

(5) The covered person's benefit maximums were reached on or before the date the service was delivered.

e. A change in a carrier's coverage or approval criteria for a previously approved health care service does not affect a covered person who received a prior authorization before the effective date of the change for the remainder of the covered person's plan year as long as the service(s) and treatment(s) are obtained from a contracted medical facility or health care professional, as applicable.

Section 9 Emergency Services

A. A carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent layperson having average knowledge of health care services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed. Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure by the covered person or the emergency service medical facility or health care professional to secure prior authorization.

B. With respect to care obtained from a non-contracted medical facility or health care professional within the service area of a managed care plan, a carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracted medical facility or health care professional would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific medical facility or health care professional.

C. Health maintenance organizations shall also comply with the life or limb threatening emergency coverage provisions of § 10-16-407(2), C.R.S., in reviewing claims for emergency services necessary to screen and stabilize a covered person.

Section 10 Peer-to-Peer Conversation

A. In a case involving a prospective review determination, a carrier shall give the medical facility aor health care professional rendering the service an opportunity to request, on behalf of the covered person, a peer-to-peer conversation regarding an adverse determination by the reviewer making the adverse determination. Such a request may be made either orally or in writing.

B. The peer-to-peer conversation shall occur within five (5) calendar days of the carrier's receipt of the request and shall be conducted between the medical facility or health care professional rendering the health care service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within five (5) calendar days.

C. If the peer-to-peer conversation does not resolve the difference of opinion, the adverse determination may be appealed by the covered person. A peer-to-peer conversation is not a prerequisite to a first level review or an expedited review of an adverse determination.

D. For the purposes of § 10-3-1104(1)(i), C.R.S., a request for a peer-to-peer conversation shall not be considered a complaint.

Section 11 First Level Review

A. General requirements.

1. A carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request in compliance with § 10-16-113, C.R.S., and this regulation. The procedures shall specify whether a first level review request must be in writing or may be submitted orally. The procedures shall also allow the covered person to identify the medical facility and health care professionals to whom the carrier shall send a copy of the review decision.

2. A first level review shall be available to, and may be initiated by, the covered person. For purposes of this section, "covered person" includes the designated representative of a covered person.

3. Pursuant to § 10-3-1104(1)(i), C.R.S., all written requests for a first level review shall be entered into the carrier's complaint record.

4. Within 180 calendar days after the date of receipt of a notice of an adverse determination sent pursuant to sections 7 or 8 or after the date of receipt of notification of a benefit denied due to a contractual exclusion, a covered person may file a grievance with the carrier requesting a first level review of the adverse determination. In order to secure a first level review after the receipt of the notification of a benefit denied due to a contractual exclusion, the covered person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.

5. Full and fair review.

   a. Before issuing a final internal adverse benefit determination based on new and/or additional evidence, the carrier shall provide the covered person, free of charge, the new and/or additional evidence considered, relied upon, or generated by the carrier in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 11.E. to give the covered person a reasonable opportunity to respond prior to that date.

   b. Before issuing a final internal adverse benefit determination based on new and/or additional rationale, the carrier shall provide the covered person, free of charge, with the rationale considered, relied upon, or generated by the carrier in connection with the claim. Such rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 11.E. to give the covered person a reasonable opportunity to respond prior to that date.

B. Individual health coverage plans.

1. Covered persons shall be provided a choice between a written appeal review and a review meeting for their first level appeal.

2. Written appeal reviews shall comply with the requirements of section 11.C.

3. Review meetings shall comply with the requirements of section 12. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review meeting.

4. The covered person is entitled to a single internal appeal review.

C. Conduct of first level written appeal reviews.

1. First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer(s), unless the reviewing physician is a clinical peer, except that, in the case of dental care, a dentist may evaluate the appeal, and the reviewing dentist shall consult with an appropriate clinical peer or peers. The physician, dentist, or clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

2. In conducting a review under this section, the reviewer(s) shall take into consideration all comments, documents, records, and other information regarding the request for services or benefits submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination. If the appeal is pursuant to § 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

D. Covered person's rights for first level written appeal review for individual and group health coverage plans. A covered person is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits for the reviewer(s) to consider when conducting the review. For review of a benefit denial due to a contractual exclusion, the covered person shall provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply; and

2. Receive from the carrier, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the covered person's request for benefits. A document, record, or other information shall be considered "relevant" to a covered person's request for benefits if the document, record, or other information:

a. Was relied upon in making the benefit determination;

b. Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination;

c. Demonstrates that, in making the benefit determination, the carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as with other similarly-situated covered persons; and/or

d. Constitutes a statement of policy or guidance with respect to the health coverage plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

3. A covered person does not have the right to be present for the written appeal review.

E. Notification requirements.

1. A carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in section 11.E.2.

2. With respect to a request for a first level review of an adverse determination involving a prospective review request, the carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) calendar days after the date of the carrier's receipt of the grievance containing a request for the first level review.

3. With respect to a request for a first level review of an adverse determination involving a retrospective review request, the carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) calendar days after the date of the carrier's receipt of a request for the first level review.

F. For purposes of calculating the time periods within which a determination is required to be made and notice provided under section 11.E.3., the time period shall begin on the date of the carrier's receipt of the grievance requesting the review provided in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

G. The decision issued pursuant to section 11.E. shall set forth in a manner calculated to be understood by the covered person:

1. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consulted. For the purposes of section 11, the physician and consulting clinical peers shall be called "the reviewers";

2. A statement of the reviewers' understanding of the covered person's request for a review of an adverse determination;

3. The reviewers' decision in clear terms; and

4. A reference to the evidence or documentation used as the basis for the decision.

H. A first level review decision involving an adverse determination issued pursuant to section 11.E. shall include, in addition to the requirements of section 11.G.:

1. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, as the term "relevant" is defined in section 11.D.2., to the covered person's benefit request;

3. If the reviewers relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

4. If the adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limitation, either an explanation of the

scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

5. Information sufficient for the covered person to be able to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

6. If applicable, instructions for requesting:

   a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 11.H.3.;

   b. The written statement of the scientific or clinical rationale for the determination, as provided in section 11.H.4.; and/or

   c. The information necessary to identify the claim, as provided in section 11.H.5.; and

7. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to section 5 of Colorado Insurance Regulation 4-2-21.

8. For group health coverage plans, a description of the process to obtain a voluntary second level review, including:

   a. The written procedures governing the voluntary second level review, including the required time frames for the review;

   b. The right of the covered person to:

      (1) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the carrier, a review panel of health care professionals, who have appropriate expertise, who were not previously involved in the appeal, and who do not have a direct financial interest in the outcome of the review;

      (2) Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable;

      (3) Present written comments, documents, records, and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;

         (a) A copy of the materials the covered person plans to present or have presented on his or her behalf at the review meeting should be provided to the carrier at least five (5) calendar days prior to the date of the review meeting;

         (b) Any new material developed after the five-day deadline shall be provided to the carrier when practicable;

      (4) Present the covered person's case to the reviewer or review panel;

(5) If applicable, ask questions of the reviewer or review panel; and

(6) Be assisted or represented by an individual(s) of the covered person's choice, including counsel, advocates, and health care professionals;

c. A statement that the carrier will provide to the covered person, upon request, sufficient information relating to the voluntary second level review to enable the covered person to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker.

d. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to section 5 of Colorado Insurance Regulation 4-2-21 if the covered person chooses not to request a voluntary second level review of the first level review decision involving an adverse determination.

Section 12 General Requirements for First Level and Voluntary Second Level Review Meetings

A. A carrier shall establish written procedures in compliance with all of the requirements of this section for a review process in which the covered person has the right to appear in person or by telephone conference at the review meeting before a health care professional (reviewer) or, if offered by the carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify the medical facility and health care professional(s) to whom the carrier shall send a copy of the review decision. The purpose of the review meeting process is to give the covered person the opportunity to explain his or her grievance and to provide any relevant evidence in support of his or her claim for benefits.

B. For purposes of this section, "covered person" includes the designated representative of a covered person.

C. A complaint record entry shall be made for all review meeting requests, pursuant to § 10-3-1104(1)(i), C.R.S.

D. Covered person's review request filing requirements.

1. For individual health coverage plans, the requirements of section 11.A.4. apply.

2. For group health coverage plans, within sixty (60) calendar days after the date of receipt of a notice of a first level review adverse determination, the covered person may file a request with the carrier requesting a voluntary second level review of the adverse determination. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day.

E. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review meeting.

F. Carrier's requirements.

1. The adverse determination or, with respect to a voluntary second level review of a first level review decision, the denial shall be reviewed by a health care professional

(reviewer) or, if offered by the carrier, a review panel of health care professionals, who have appropriate expertise in relation to the case presented by the covered person.

2. The reviewer or each review panel member, shall meet the following criteria:

   a. Were not previously involved in the appeal;

   b. Do not have a direct financial interest in the appeal or outcome of the review; and

   c. Are not a subordinate of any person previously involved in the appeal.

3. The reviewer or the review panel shall have the legal authority to bind the carrier to the reviewer's or review panel's decision.

G. The carrier's procedures for conducting a review meeting shall include the following:

1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) calendar days of the carrier's receipt of a request from a covered person for a review meeting. The covered person shall be notified in writing at least twenty (20) calendar days in advance of the review meeting date. The carrier shall not unreasonably deny a request for postponement of the review meeting made by a covered person even if the postponement causes the review meeting to occur beyond the sixty (60) calendar day requirement.

2. Notice requirements. The notice to the covered person of the review meeting date shall include:

   a. The right of the covered person to present written comments, documents, records, and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting.

   b. The right of the covered person to receive, upon request, a copy of the materials that the carrier intends to present at the review meeting at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable.

   c. The responsibility of the covered person to submit a copy of the materials that the covered person plans to present or have presented on his or her behalf at the review meeting to the carrier at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided to the carrier when practicable.

   d. The responsibility of the covered person to, within seven (7) calendar days in advance of the review meeting, inform the carrier if the covered person intends to have an attorney present to represent such person's interests. If the covered person decides to have an attorney present after the seven-day deadline, notice shall be provided to the carrier when practicable.

   e. The carrier shall use this notification to advise the covered person if it intends to have an attorney present to represent the interests of the carrier.

   f. The carrier shall use this notification to advise the covered person that it will make an audio or video recording of the review meeting unless neither the covered person nor the carrier wants the recording made. The notice shall advise

that this recording will be made available to the covered person and that if there is an external review, the audio or video recording shall be included in the material provided by the carrier to the reviewing entity unless the covered person specifically requests that it not be included.

3. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. Whenever a covered person has requested the opportunity to appear in person, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a carrier shall offer the covered person the opportunity to communicate, at the carrier's expense, by telephone conference call. A carrier may also offer video conferencing or other appropriate technology.

4. In conducting the review meeting, if applicable, the reviewer or review panel shall take into consideration all comments, documents, records, and other information regarding the request for benefits submitted by the covered person without regard to whether the information was submitted or considered in reaching the first level review decision. If the appeal is pursuant to § 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

5. Full and fair review.

   a. Before issuing a final internal adverse benefit determination based on new and/or additional evidence, the carrier shall provide the covered person, free of charge, the new and/or additional evidence considered, relied upon, or generated by the carrier in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 12.G.6. to give the covered person a reasonable opportunity to respond prior to that date.

   b. Before issuing a final internal adverse benefit determination based on new and/or additional rationale, the carrier shall provide the covered person, free of charge, with the rationale considered, relied upon, or generated by the carrier in connection with the claim. Such rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal adverse benefit determination is required to be provided pursuant to section 12.G.6. to give the covered person a reasonable opportunity to respond prior to that date.

6. The reviewer or review panel shall issue a written decision, as provided in section 12.H., to the covered person within seven (7) calendar days of completing the review meeting.

7. For purposes of calculating the time periods within which a review meeting is required to be scheduled, the time period shall begin on the date of the carrier’s receipt of the request for a review meeting provided in accordance with the carrier’s procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

H. A decision issued pursuant to section 12.G. shall include:

1. The name(s), title(s), and qualifying credentials of the reviewer or the members of the review panel;

2. A statement of the reviewer's or the review panel's understanding of the covered person's request for review of an adverse determination;

3. The reviewer's or the review panel's decision in clear terms;

4. A reference to the evidence or documentation used as the basis for the decision;

5. For a decision issued involving an adverse determination:

   a. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

   b. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, as the term "relevant" is defined in section 11.D.2., to the covered person's benefit request;

   c. If the reviewer or review panel relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

   d. If the adverse determination is based on a medical necessity, experimental or investigational treatment, or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

   e. If applicable, instructions for requesting:

      (1) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in section 12.H.5.c.; and

      (2) The written statement of the scientific or clinical rationale for the determination, as provided in section 12.H.5.d.; and

   f. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to section 5 of Colorado Insurance Regulation 4-2-21.

Section 13 Expedited Review of an Adverse Determination

A. A carrier shall establish written procedures in compliance with all of the requirements of this section for the expedited review of urgent care requests or grievances involving an adverse determination. A carrier shall also provide an expedited review for a request for a benefit for a covered person who has received emergency services but has not been discharged from a medical facility. The procedures shall allow a covered person to request an expedited review under this section orally or in writing. The procedures shall also allow the covered person to identify a medical facility and health care professional(s) to whom the carrier shall send a copy of the review decision. Pursuant to § 10-16-113.5(7), C.R.S., a covered person requesting an

expedited external review may request such review concurrently with a request for an expedited internal review.

B. An expedited review shall be available to, and may be initiated by, the covered person or the medical facility and/or health care professional acting on behalf of the covered person. For purposes of this section, "covered person" includes the designated representative of a covered person.

C. Pursuant to § 10-3-1104(1)(i), C.R.S., all written requests for an expedited review shall be entered into the carrier's complaint record.

D. Expedited appeal evaluations.

1. Expedited appeals shall be evaluated by an appropriate clinical peer(s) in the same or similar specialty as would typically manage the case under review. For the purposes of this section, the clinical peer(s) shall be called "the reviewer(s)". The clinical peer(s) shall not have been involved in the initial adverse determination.

2. In conducting a review under this section, the reviewer(s) shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by, or on behalf of, the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.

E. Covered person's rights. A covered person does not have the right to attend or to have a representative in attendance at the expedited review, but the covered person is entitled to:

1. Submit written comments, documents, records, and other materials relating to the request for benefits for the reviewer(s) to consider when conducting the review; and

2. Receive from the carrier, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the covered person's request for benefits, as described in section 11.D.2.

F. In an expedited review, all necessary information, including the carrier's decision, shall be transmitted between the carrier and the covered person or the medical facility and/or health care professional acting on behalf of the covered person by telephone, facsimile or similar expeditious method available.

G. In an expedited review, a carrier shall make a decision and notify the covered person or the medical facility and/or health care professional acting on the covered person's behalf as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the carrier's receipt of the request. If the expedited review is a concurrent review and an adverse determination is made, the health care service or treatment shall continue to be covered according to the provisions of the health coverage plan until the covered person has been notified of the determination by the carrier.

H. A carrier shall provide a written confirmation of its decision concerning an expedited review within three (3) calendar days of providing notification of that decision, if the initial notification was not in writing.

I. In the case of an adverse determination, the written decision shall comply with the requirements specified in sections 11.G. and 11.H. of this regulation.

J. For purposes of calculating the time periods within which a decision is required to be made under section 13.G., the time period within which the decision is required to be made shall begin on the

date of the carrier's receipt of the request in accordance with the carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the request.

K. In any case where the expedited review process does not resolve a difference of opinion between the carrier and the covered person or the medical facility and/or health care professional acting on behalf of the covered person, the covered person or the medical facility and/or health care professional acting on behalf of the covered person may request an independent external review.

L. Retrospective adverse determinations are not eligible for the expedited review process.

Section 14 Rescission and Initial Eligibility Determinations

A. The rescission of coverage and denials of coverage to an individual based on initial eligibility determinations are considered adverse determinations for the purposes of this regulation.

B. A carrier shall provide notice thirty (30) calendar days in advance of the policy rescission to each person covered by the policy.

C. An individual has the right to appeal a rescission or denial of coverage based on an initial coverage determination in accordance with sections 11 and 12 of this regulation. However, a physician or panel of health care professionals is not required to evaluate these appeals or consult with an appropriate clinical peer pursuant to § 10-16-113(4)(b)(II), C.R.S.

D. The carrier's rescission notification or denial of coverage based on an initial coverage determination do not have to be reviewed and signed by a physician.

Section 15 Severability

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

Section 16 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 17 Effective Date

This amended regulation is effective on ~~March 15, 2021~~January 1, 2026.

Section 18 History

Originally promulgated effective July 1, 1997.
Amended effective April 1, 2000.
Amended effective April 1, 2004 to comply with ERISA claims/appeals procedures.
Amended effective October 1, 2004, to correct internal references and to provide clarification with respect to the expedited appeal.
Emergency Regulation 05-E-5 effective January 1, 2006.
Amended effective February 1, 2006.
Amended regulation effective November 1, 2010.
Amended regulation effective December 1, 2013.
Amended regulation effective June 1, 2019.

Amended regulation effective August 1, 2020.
Amended regulation effective March 15, 2021.
Amended regulation effective January 1, 2026.