Notice of Grievance Procedures

In accordance with 3 CCR 702 Reg. 4-2-17 and
3 CCR 702 Reg. 4-2-21
of the Colorado Insurance Regulations

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328

Please read this notice carefully to see important information about how to file grievances with us. We can help you file a grievance or review any questions about our benefit decisions or claims payments. You also have the right to contact the Colorado Division of Insurance if you have a question or concern regarding your coverage, using the contact information below:

In Writing:	Colorado Division of Insurance 1560 Broadway, Suite 850 Denver, CO 80202
By phone:	800-930-3745
Website:	www.dora.state.co.us/insurance

I. Definitions

"Adverse Determination" means a determination made by us or our designee that a request for a benefit has been reviewed and, based upon the information provided, does not meet our requirement for medical necessity, or is determined to be experimental or investigational, and is therefore denied, reduced or terminated. An adverse determination also includes a denial due to a contractual exclusion when 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.

"Grievance" means a written complaint on by or on behalf of a Covered Person regarding claims payment, handling, or reimbursement for health care services, including a grievance concerning an adverse determination.

"Designated Representative" means a Person, including the treating provider or a Person to whom the Covered Person has given express written consent to represent the Covered Person, or 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.

"Utilization Review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings.

II. Levels of Review

The following levels of review will be available to a Covered Person and/or designated representative:

First Level Grievance Review - for written grievances, including those resulting from an adverse determination.

Voluntary Second Level Grievance Review - following first-level reviews if grievance not resolved.

Expedited Review - only for adverse determinations of requests for urgent care pre-treatment benefit estimates.

External Review - available following either the first or second level review for adverse determinations.

A. First Level Grievance Review

A written grievance concerning any matter, including an adverse determination, may be submitted by a Covered Person or his or her designated representative, within 180 calendar days of receipt of the adverse determination. A Covered Person does not have the right to attend or to have a representative in attendance at the first level review, but the Covered Person is entitled to 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 must be able to provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply. The Covered Person has the right to receive 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. We will send a written decision to the Covered Person and designated provider no later than thirty (30) calendar days after receiving a request for first level review. The review of an adverse determination will be conducted by a clinical peer other than the Person or Persons who made the initial determination on the matter.

B. Voluntary Second Level Grievance Review

In any case where the first level grievance review process or expedited review process involving an adverse determination does not resolve a difference of opinion, the Covered Person or their designated representative may request a second level review. We will provide the Covered Person, upon request, information relating to the voluntary second level review so that the Covered Person can make an informed decision whether to submit the adverse determination to a voluntary second level review. The request for a second level review should be made within thirty (30) calendar days after receipt of the decision resulting from the first level review. The Covered Person may designate the provider(s) to whom we shall send a copy of the review decision.

We will appoint a review panel to review the request. The panel will include a minimum of three (3) people, the majority of whom will not have been previously involved in the grievance. If the review is regarding an adverse determination, the majority of Persons reviewing the request will be clinical peers who have appropriate expertise.

The review panel will meet within sixty (60) calendar days after receiving a request from a Covered Person or designated representative for a voluntary second-level review. The Covered Person shall be notified at least twenty (20) calendar days in advance of the review date.

The Covered Person or designated representative has the right to appear in Person or through conference call at the review meeting and can present written comments or materials relating to the review. These

documents should be sent to us at least five (5) calendar days prior to the meeting. Any new material developed after the 5-day deadline must be sent as soon as practicable.

The Covered Person has the right to receive, upon request, a copy of the materials that we intend to present at the review meeting at least five (5) calendar days prior to the meeting. Any new material developed after the 5-day deadline will be provided as soon as practicable if the Covered Person had requested materials previously.

The Covered Person has the right to have an attorney at the review meeting and should advise us of this no later than seven (7) calendar days prior to the meeting. If the decision to have an attorney present is made after the 7-day deadline, notice will be provided to us as soon as practicable. If we plan to have an attorney present, we will advise the Covered Person at the time we advise the review date.

If we plan to make an audio or video recording of the review, we will advise the Covered Person at the time we advise the review date. Such a recording may be provided to any external review entity should one be held after the Second Level Review.

The review panel will issue a written decision to the Covered Person within seven (7) calendar days of the review meeting.

C. Expedited Review – Available for Adverse Pre-Treatment Benefit Estimates Only

Pre-authorization of benefits is not required under our plans. For urgent care situations, an expedited review of an elective pre-treatment benefit determination can be requested orally or in writing. A request for a concurrent expedited External Review may be made at the same time (see below for more information on External Review). Expedited reviews of an adverse determination will be reviewed by clinical peers in the same or similar specialty as would normally manage the case under review, different from those who were involved in the initial adverse determination. A Covered Person or representative does not have the right to attend the expedited review, but can submit related written comments, documents and records.

We will make a decision and notify the Covered Person or their designated representative no later than seventy-two (72) hours after the carrier's receipt of request. Written confirmation of the decision will be provided within three (3) calendar days of the decision, if the initial notification was not in writing.

If the expedited review does not resolve a difference of opinion, a voluntary second level review is available, as described in B. above.

D. Independent External Review for Adverse Determinations (Benefit Decisions Based on Medical Necessity)

The Covered Person has a right to request an independent external review if there still remains a difference of opinion following any internal reviews or if we fail to properly follow required Internal Review procedures.

The Covered Person or representative can request an External Review four (4) months after receipt of an adverse decision following a First Level Grievance Review, or sixty (60) calendar days after receipt of an adverse decision following a Second Level Grievance Review. Requests for external review must be made in writing to us and include a completed external review request form as specified by the Division of Insurance and a consent form authorizing us to disclose any health information necessary

during the review. New information may also be submitted by the Covered Person or provider related to the matter in question. There is no minimum dollar amount for a claim to be eligible for an external review.

If we were to deny a request for a standard external review, we will send notification in writing or electronically, including the specific reasons for the denial and information about how to appeal the denial of the request with the Division of Insurance. A copy of this denial will be sent to the Division at the same time it is sent to the Covered Person.

When we receive a request for external review, we will send a copy to the Commissioner of Insurance within two (2) working days, If the request is incomplete, we will notify the covered person within five (5) days after receipt of an incomplete request for a standard external review and within 24 hours of receipt of an incomplete request for an expedited external review.

If we reverse an adverse determination based on new or additional information submitted to us, before the required time for notifying the Commissioner, we will notify the covered person within one (1) business day of the reversed decision by electronic or fax delivery, or by telephone followed by written confirmation.

Within two (2) business days of receipt of a request, the Division of Insurance will randomly select an independent review organization that does not have a conflict of interest to review the matter. Upon selection, the Division will notify us of the name and address of the independent external review organization where the appeal should be sent.

Within one (1) business day, we will then notify the Covered Person of this information, electronically, by fax, or by telephone followed by written confirmation. The notice will include a written description of the independent external review entity the Commissioner selected and information regarding how the Covered Person may provide the Commissioner with any documentation regarding potential conflict of interest concerns. The Covered Person has two (2) business days after that to submit such documentation.

Within one (1) business day after the Commissioner determines necessary, the Commissioner will assign a different entity and notify us of the new information so that we can send the appeal information.

Within five (5) business days of receipt of the notice from us, the Covered Person may submit additional information to the independent external review entity for consideration during the review. The independent entity may also choose to accept additional information after the five day period but is not required to do so. Information received will also be forwarded to us within one (1) business day of receipt.

The independent external review entity is not bound by any determinations made by us.

We will provide all requested information to the independent review entity within five (5) business days, including an index of submitted materials.

Within two (2) days after receipt of these materials, the independent review entity will send the Covered Person the index.

If the review entity requests additional information from the Covered Person, the provider, or us, the information must be submitted within five (5) business days or an explanation as to the unavailability of such information must be submitted within that time frame.

The independent review entity will communicate its decision within forty-five (45) calendar days after receipt of the request for the external review. Written notification will be sent to the Covered Person, the carrier, the provider, and the Commissioner.

If the independent review entity decides that a benefit is payable:

a. For prospective pre-treatment estimate reviews, we will approve the benefit within one (1) business day.
b. For retrospective treatment claim reviews, we will approve the benefit within five (5) business days.

We will provide written notice of the approval to the Covered Person or designated representative within one (1) business day of our approval. Coverage will be subject to the terms and conditions of the policy.

External review decisions are binding on us and the Covered Person, except to the extent there are other remedies available under federal or state law. Additional external review requests for the same matter are not permitted.

Further details about the external review process will be provided upon request or at the time an external review is requested.

E. Expedited External Review

No pre-authorizations are required under our policies. However**, t**he Covered Person or designated representative has a right to request an expedited external review of a request for a pre-treatment estimate of benefits if the Covered Person has a medical condition where the timeframes for completion of a standard external review would seriously jeopardize the health of the Covered Person. All requests for an expedited external review must include a physician's certification that the Covered Person's medical condition meets the criteria as defined above. Upon receipt of a request for an expedited external review, we will send a copy of the request to the Commissioner of Insurance within one (1) business day electronically or by telephone or fax.

Other steps described above will be performed in an expeditious manner. The Commissioner will randomly assign the independent external review entity within one (1) business day of receipt of the request for an expedited external review. Within one (1) business day of receiving such notice from the Commissioner, we will notify the Covered Person of such entity, followed up in writing if such notice was made by telephone. We will immediately submit all related information to the independent review entity in the most expeditious manner.

The independent review entity will communicate its determination within 72 hours to the Covered Person, the carrier, the provider, and the Commissioner.

III. Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

1. The names, titles and qualifying credentials of the Persons participating in the grievance review process.

2. A statement of the reviewer's understanding of the grievance.

3. The decision stated in clear terms, and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision.

4. A description of our review procedures, any time limits applicable to such procedures, and any appeals rights.

5. A description of any additional material or information necessary and an explanation of why such material or information is necessary for any further review.

6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or a statement that such rule, guideline, or protocol, was relied upon and that a copy will be provided free upon request.

7. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the Covered Person's medical circumstances or a statement that such explanation will be provided free of charge upon request.

8. For first level reviews, a description of the process to obtain a second level grievance review and the time frame for review. Following a second level review, a description of the process to request an independent external review.

9. Notice of the Covered Person's right to contact the Colorado Division of Insurance.

Additional Review Rights

The Covered Person whose claim has been denied in whole or in part, and who has exhausted his or her administrative remedies, shall be entitled to have his or her claim reviewed from the beginning in any court with jurisdiction and to a trial by jury.

You always have the right to contact the Department of Insurance:

Colorado Division of Insurance
1560 Broadway Suite #850
Denver, CO 80202
(303) 894-7490
(800) 930-3745 – Toll Free if calling from outside Denver metro area

Cultural and Linguistic Support

We want to be sure this information is helpful to you. Interpreting services are available toll free at 800-487-5553. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY "text telephone" systems when contacting us.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 800-487-5553.