

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES

DIVISION OF INSURANCE
1560 Broadway, Suite 850
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Amended Regulation 4-2-17

PROMPT INVESTIGATION OF HEALTH PLAN CLAIMS INVOLVING UTILIZATION REVIEW AND DENIAL OF BENEFITS

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Section 1 Authority

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

Section 2 Background and Purpose

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Sections 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 described herein. Among other things, Section 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from insurance policies; 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 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 replaces Colorado Emergency Regulation 05-E-5 in its entirety.

This regulation is designed to provide minimum standards for handling appeals and grievances involving utilization review determinations and certain denials of benefits for treatments excluded by health coverage plans.

Section 3 Applicability and Scope

The provisions of this regulation shall apply to all health coverage plans, but 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, except 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.

Section 4 Definitions¹

- A. "Adverse determination" means a determination by a health carrier or its designee that request for a benefit has been reviewed and, based upon the information provided, does not meet the health carrier's 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 for a benefit excluded by a health coverage plan for which the claimant 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.
- B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.
- C. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- D. "Clinical peer" means 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.
- E. "Complaint" means a written communication primarily expressing a grievance.
- F. "Designated representative" means:
 - 1. A person, including the treating health care professional or a person authorized by Paragraph 2 of this Subsection F., to whom a covered person has given express written consent to represent the covered person; or
 - 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, or a proxy; or
 - 3. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.
- G. "Discharge planning" means the formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service.

¹ In addition to the terms defined in this section, the following terms are defined in statute (see Section 10-16-102, C.R.S.): "carrier", "covered person", and "health coverage plan".

- H. “Emergency medical condition” means 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 person’s health in serious jeopardy.
- I. “Grievance” means a circumstance regarded as a cause for protest, including the protest of an adverse determination.
- J. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.
- K. “Life or limb threatening emergency” shall have the same meaning as defined in Section 10-16-407(2), C.R.S.
- L. “Medical professional” means an individual licensed pursuant to the “Colorado Medical Practice Act”, article 36 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the “Dental Practice Law of Colorado”, article 35 of title 12, C.R.S., acting within his or her scope of practice.
- M. “Prospective review” means utilization review conducted prior to an admission or course of treatment.
- N. “Provider” shall have the same meaning as defined in Section 10-16-102(36), C.R.S.
- O. “Retrospective review” means any utilization review that is not prospective review, but does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.
- P. “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.
- Q. “Stabilized” means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.
- R. “Urgent care request” means:
 - 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 persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently, or
 - b. In the opinion of a physician 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 Paragraph 3 of this Subsection R., in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
 3. Any request that a physician with knowledge of the covered person's medical condition determines and states is an urgent care request within the meaning of Paragraph 1 shall be treated as an urgent care request.
- S. "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. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include 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. A health carrier that does not use a procedure for investigating claims involving utilization review that is consistent with this regulation shall be deemed not to be in compliance with 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.
(Section 10-3-1104(1)(h)(IV), C.R.S.)
- B. A health carrier that uses standards in the review of claims involving utilization review that are not in compliance with the rules contained in this regulation shall be deemed not to be in compliance with 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.
(Section 10-3-1104(1)(h)(III), C.R.S.)
- C. A health carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims.
(Section 10-3-1104(1)(h)(II), C.R.S.)
- D. A health carrier that does not follow the procedures for explaining the basis of a utilization review decision set forth in this regulation shall be deemed not to be in compliance with 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.
(Section 10-3-1104(1)(h)(XIV), C.R.S.)
- E. A health 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 not to be in compliance with

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.
(Section 10-3-1104(1)(h)(IV), C.R.S.)

Section 6 Standard Utilization Review

- A. A health carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.
- B. Prospective review determinations.
 - 1. Time period for determination and notification.
 - a. Subject to Subparagraph b. of Paragraph 1., a health carrier shall make the determination and notify the covered person and the covered person's provider 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) days after the date the health carrier receives the request. Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.
 - b. The time period for making a determination and notifying the covered person of the determination pursuant to Subparagraph a. of Paragraph 1. may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:
 - (i) Determines that an extension is necessary due to matters beyond the health carrier's control; and
 - (ii) Notifies the covered person prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.
 - c. If the extension under Subparagraph b. of Paragraph 1. 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:
 - (i) Specifically describe the required information necessary to complete the request; and
 - (ii) Give the covered person at least forty-five (45) days from the date of receipt of the notice to provide the specified information.
 - 2. Failure to meet the health carrier's filing procedures.
 - a. Whenever the health carrier receives a prospective review request from a covered person that fails to meet the health carrier's filing procedures, the health 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.
 - (i) The notice required under Subparagraph a. of Paragraph 2. shall be provided, as soon as possible, but in no event later than five (5) days following the date of the failure.
 - (ii) The health carrier must provide the notice in writing.
- c. The provisions of Paragraph 2. shall apply only in the case of a failure that:
 - (i) Is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
 - (ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification 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, the health care service or treatment that is the subject of an adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the carrier.

C. Retrospective review determinations.

- 1. For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request. If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection 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 Paragraph 1. may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:
 - (i) Determines that an extension is necessary due to matters beyond the health carrier's control; and
 - (ii) Notifies the covered person prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.
 - b. If the extension under Subparagraph a. of Paragraph 2. 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:
 - (i) Specifically describe the required information necessary to complete the request; and

- (ii) Give the covered person at least thirty (30) days from the date of receipt of the notice to provide the specified information.

D. Calculation of time periods.

1. For purposes of calculating the time periods within which a determination is required to be made under Subsections B and C, the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.
2. Extensions.
 - a. If the time period for making the determination under Subsection B. or 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 health carrier sends the notification of the extension to the covered person until the earlier of:
 - (i) The date on which the covered person responds to the request for additional information; or
 - (ii) 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 Subsection B. or C., the health carrier may deny the certification of the requested benefit.

E. Requirements for adverse determination notifications.

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 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 health 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 or experimental or investigational treatment or similar exclusion or limit, 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. If applicable, instructions for requesting:
 - (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph e. of this paragraph; or
 - (ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph f. of this paragraph; and
 - h. A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;
2. A health carrier must provide the notice required under this section in writing, either on paper or electronically.

Section 7 Expedited Utilization Review

A. Procedures.

1. A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons and for making and notifying covered persons of expedited utilization review with respect to urgent care requests. For purposes of this section, "covered person" includes the designated representative of a covered person.
2. Notification requirements.
 - a. As part of the procedures required under Paragraph 1., a health carrier shall provide that, in the case of a failure by a covered person to follow the health carrier's procedures for filing an urgent care request, the covered person shall be notified of the failure and the proper procedures to be following for filing the request.
 - b. The notice required under Subparagraph a. of this paragraph:
 - (i) Shall be provided to the covered person as soon as possible but not later than twenty-four (24) hours after receipt of the request; and
 - (ii) Must be in writing.
 - c. The provisions of this paragraph apply only in the case of a failure that:
 - (i) Is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

- (ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider 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 health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health coverage plan, the health carrier shall notify the covered person and the covered person's provider of the health 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 receipt of the request by the health carrier.
- b. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

2. Notification requirements for insufficient information.

- a. If the covered person has failed to provide sufficient information for the health carrier to make a determination, the health 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 receipt of the request.
- b. The health 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 Subparagraph a. of this paragraph.
- c. The health carrier shall notify the covered person and the covered person's provider 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:
 - (i) The health carrier's receipt of the requested specified information; or
 - (ii) 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 Subparagraph b. of this paragraph, the health carrier may deny the certification of the requested benefit.
- e. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

C. Concurrent urgent care review requests.

1. For concurrent review urgent care 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 health carrier shall make a determination with respect to the request and notify the covered person and the covered person's provider 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 health carrier's receipt of the request.
 2. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.
- D. For purposes of calculating the time periods within which a determination is required to be made under Subsection B. or C., the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.
- 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 to perfect the request;
 - e. If the health 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 or experimental or investigational treatment or similar exclusion or limit, 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. If applicable, instructions for requesting:
 - (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in

making the adverse determination, as provided in Subparagraph e. of this paragraph;
or

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph f. of this paragraph; and

h. A description of the health coverage plan's expedited review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;

2. Notification requirements.

a. A health 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 health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

Section 8 Emergency Services

- A. A health 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 lay person having average knowledge of health 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 provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health 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 contracting provider 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 provider.
- B. Health maintenance organizations shall also comply with the life or limb threatening emergency coverage provisions of Section 10-16-407(2), C.R.S., in reviewing claims for emergency services necessary to screen and stabilize a covered person.

Section 9 Peer-to-Peer Conversation

- A. In a case involving a prospective review determination, a health carrier shall give the provider 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) days of the receipt of the request and shall be conducted between the provider rendering the 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) 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 Section 10-3-1104(1)(i), C.R.S., and Colorado Insurance Regulation 6-2-1 concerning complaints and complaint records, a request for a peer-to-peer conversation shall not be considered a complaint.

Section 10 First Level Review

- A. A health carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request. 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 providers to whom the health carrier shall send a copy of the review decision.
- B. 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.
- C. Pursuant to Section 10-3-1104(1)(i), C.R.S., all written requests for a first level review must be entered into the carrier's complaint record.
- D. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Section 6 or 7 or after the receipt of notification of a benefit denied due to a contractual exclusion, a covered person may file a grievance with the health 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.
- E. Conduct of first level reviews.
 - 1. First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer. The physician and 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 or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services 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 Section 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.
- F. Covered person's rights.
 - 1. 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:

- a. Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers 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

- b. Receive from the health 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.
2. For purposes of Subparagraph 1.b. of this subsection, 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 health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; 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.

G. Notification requirements.

1. A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in Paragraph 2. or 3.
2. With respect to a request for a first level review of an adverse determination involving a prospective review request, the health 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) days after the date of the health carrier's receipt of the grievance requesting 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 health carrier shall notify and issue a decision within a reasonable period of time, but no later than thirty (30) days after the date of the health carrier's receipt of a request for the first level review.

H. For purposes of calculating the time periods within which a determination is required to be made and notice provided under Subsection G., the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's

procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

- I. The decision issued pursuant to Subsection G. 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 consults. (For the purposes of this section, 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.
- J. A first level review decision involving an adverse determination issued pursuant to Subsection G. shall include, in addition to the requirements of Subsection I.:
 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 Subsection F.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 or experimental or investigational treatment or similar exclusion or limit, 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; and
 5. 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 Paragraph 3. of this subsection; and
 - b. The written statement of the scientific or clinical rationale for the determination, as provided in Paragraph 4. of this subsection.
 6. A description of the process to obtain a voluntary second level review, including:

- a. The written procedures governing the voluntary second level review, including any required time frames for the review;
- b. The right of the covered person to:
 - (i) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the health 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;
 - (ii) Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) 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;
 - (iii) 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 should be provided to the health carrier at least five (5) 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;
 - (iv) Present the covered person's case to the reviewer or review panel;
 - (v) If applicable, ask questions of the reviewer or review panel; and
 - (vi) Be assisted or represented by an individual of the covered person's choice, including counsel, advocates, and health care professionals;
- c. A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the claimant 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 Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination.

Section 11 Voluntary Second Level Review

- A. A carrier shall establish a voluntary review process to give those covered persons who are

dissatisfied with the first level review decision the option to request a voluntary second level review, at 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 health carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the second level review decision. The purpose of the voluntary review process is to give the covered person the opportunity to explain their grievance and to provide any relevant evidence in support of their 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 voluntary second level reviews, pursuant to Section 10-3-1104(1)(i), C.R.S., and Colorado Insurance Regulation 6-2-1.
- D. Within thirty (30) days after the date of receipt of a notice of an adverse determination, a covered person may file a request with the carrier requesting a voluntary second level review of the adverse determination.
- E. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.
- F. Procedures.
 - 1. 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 health carrier, a review panel of health care professionals, who have appropriate expertise in relation to the case presented by the covered person. The reviewer or review panel, shall meet the following criteria: were not previously involved in the appeal and who do not have a direct financial interest in the appeal or outcome of the review. The reviewer or the review panel shall have the legal authority to bind the health carrier to the reviewer's or review panel's decision.
- G. A health carrier's procedures for conducting a voluntary second level review shall include the following:
 - 1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for a voluntary second level review. The covered person shall be notified in writing at least twenty (20) days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.
 - 2. Notice requirements. The notice to the covered person of the review 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 at least five (5) 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 to the health carrier at least five (5) 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) days in advance of the review, 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 will be provided to the carrier when practicable.
 - e. The health carrier shall use this notification to advise the covered person if it intends to have an attorney present to represent the interests of the health carrier.
 - f. The health carrier shall use this notification to advise the covered person that the plan shall make an audio or video recording of the review unless neither the covered person nor the health carrier wants the recording made. The notice shall advise that this recording shall be made available to the covered person and that if there is an external review, the audio or video recording shall, at the request of either party, be included in the material provided by the carrier to the reviewing entity.
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 health carrier shall offer the covered person the opportunity to communicate, at the health carrier's expense, by telephone conference call. A carrier may also offer video conferencing or other appropriate technology.
 4. In conducting the review, 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 pursuant to Section 10.J.6.b., without regard to whether the information was submitted or considered in reaching the first level review decision. If the appeal is pursuant to Section 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. The reviewer or review panel shall issue a written decision, as provided in Subsection H., to the covered person within seven (7) days of completing the review meeting.
 6. For purposes of calculating the time periods within which a decision is required to be made and notice provided, the time period shall begin on the date the request for a voluntary second level review is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

- H. A decision issued pursuant to Subsection G. shall include:
1. The name(s), title(s) and qualifying credentials of the reviewer or 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 voluntary second level 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 10.F.2., to the covered person's benefit request;
 - c. If the reviewer or review panel has 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 or experimental or investigational treatment or similar exclusion or limit, 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; and
 - e. If applicable, instructions for requesting:
 - (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph c. of this paragraph; and
 - (ii) The written statement of the scientific or clinical rationale for the determination, as provided in Subparagraph d. of this paragraph;
 - f. A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21.

Section 12 Expedited Review of an Adverse Determination

- A. A health carrier shall establish written procedures for the expedited review of urgent care requests

of grievances involving an adverse determination. A health carrier shall also provide an expedited review to a request for a benefit for a covered person who has received emergency services but has not been discharged from a 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 providers to whom the health carrier shall send a copy of the review decision.

- B. An expedited review shall be available to, and may be initiated by, the covered person or the provider 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 Section 10-3-1104(1)(i), C.R.S., all written requests for an expedited review must be entered into the carrier's complaint record.
- D. Expedited appeal evaluations.
 - 1. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case under review. (For the purposes of this section, the clinical peers shall be called "the reviewers".) The clinical peer or peers shall not have been involved in the initial adverse determination.
 - 2. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.
- E. Covered person's rights.
 - 1. 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:
 - a. Submit written comments, documents, records and other materials relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and
 - b. Receive from the health 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 10.F.1.b.
- F. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the provider acting on behalf of the covered person by telephone, facsimile or similar expeditious method available.
- G. In an expedited review, a health carrier shall make a decision and notify the covered person or the provider 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 review is commenced. If the expedited review is a concurrent review determination, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.
- H. A health carrier shall provide written confirmation of its decision concerning an expedited review

within three (3) 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 contain the provisions specified in Sections 10.I. and 10.J. of this regulation.
- J. For purposes of calculating the time periods within which a decision is required to be made under Subsection G., the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.
- K. In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may request a voluntary second level appeal or request an independent external review.
- L. A health carrier shall not provide an expedited review for retrospective adverse determinations.

Section 13 Enforcement

Noncompliance with the requirements and time frames specified in this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of the certificate of authority. Among others, the penalties provided for in Sections 10-3-1108 and 10-3-1110(2), C.R.S., may be applied.

Section 14 Severability

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

Section 15 Effective Date

This amended regulation is hereby effective on February 1, 2006.

Section 16 History

1. Originally promulgated effective July 1, 1997.
2. Amended effective April 1, 2000.
3. Amended effective April 1, 2004 to comply with ERISA claims/appeals procedures.
4. Amended effective October 1, 2004, to correct internal references and to provide clarification with respect to the expedited appeal.
5. Emergency Regulation 05-E-5 effective January 1, 2006.
6. Amended effective February 1, 2006.