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 number 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

You also have the right to ask your insurer to assist you in filing a grievance, review its decisions involving your requests for service, or review your requests to have your claims paid.

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 by or on behalf of Covered Person submitted by Covered Person or their designated representative 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 their designated representative.

Internal Grievance Review - for written grievances and in-person grievance review meetings, including those resulting from an adverse determination.

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

External Review - available following an internal review of an adverse determination.

A. Internal 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.-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 may submit written comments, documents, records and other material relating to the request for benefits for the reviewer(s) to consider. In the alternative, the Covered Person may request an in-person review. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review meeting. Unless an in-person review is requested, we will send a written decision to the Covered Person and designated provider(s) 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 receiving a request for grievance review. The review will be conducted by a clinical peer different from the person or persons who made the initial determination on the matter.

A Covered Person has the option to request an in-person review of an adverse determination instead of a written decision. If the Covered Person chooses this option, the following standards will apply:

1. Upon receipt of a request for an in-person review meeting, 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.

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

3. 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.

4. 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.

5. The Covered Person has the right to have an attorney at the review meeting and should advise us of this within seven (7) calendar days of 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.

6. 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 review.

7. The review panel will issue a written decision to the Covered Person and designated provider(s) within seven (7) calendar days of completing 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. 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.

D. External Review
The Covered Person has a right to request an 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 4 months after receipt of an adverse decision following a First Level Grievance Review. Requests for external review must be made in writing to us and must include a completed external review request form. When we receive a request for external review, we will send a copy to the Commissioner of Insurance within two (2) business days.

E. Expedited External Review
The Covered Person has a right to request an expedited external review 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 notify and send a copy of the request to the Commissioner of Insurance within one (1) business day electronically or by telephone or facsimile.

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, furnish the Covered Person and their designated representative with 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 request an independent external review; and

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.

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.