Policy and Procedure

Policy Name: Member Appeal Process	**Policy#:** UM-106	**Version#:** 9
Author Department: UM	**Origination Date:** 09/15/2021	
Business Units Impacted: UM	**Date Last Reviewed:** 5/07/2026	
Products/LOBs: RAE and CHP+	**Date Approved by CPT:** 05/07/2026	

DEFINITIONS:

Adverse Benefit Determination[1]:

Any of the following:

1. The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; or
2. The reduction, suspension or termination of a previously authorized service; or
3. The denial, in whole or part, of payment for a service; or
4. The failure to provide services in a timely manner as defined by the State; or
5. The failure to act within the timeframes defined by the State for the resolution of grievances and appeals; or
6. The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other)

Appeal[2]: A request for review of an Adverse Benefit Determination; can be filed by a member, provider, or Designated Client Representative.

Designated Client Representative (DCR): Any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services. DCRs may be designated using the Colorado Access (COA) Authorization to Disclose PHI Form. The authorized person shall be treated as the member in all matters related to the grievance or Appeal. The DCR may request an Appeal with COA or a State Fair Hearing.

SCOPE:

This policy covers the process available to Colorado Access members, providers, and designated representatives, to appeal adverse benefit determinations and the procedures for initiating and managing those appeals.

PURPOSE:

Provide clear guidelines for requesting appeals, obtaining assistance during the appeals process, and ensuring that determinations are made based on medical necessity in compliance with regulatory standards.

STATEMENT OF POLICY:

[1] 42 CFR 438.400(b); 42 CFR 457.1260; RAE Contract 2.1.3; CHP+ Contract 2.1.1
[2] 42 CFR 438.400(b); RAE Contract 2.1.6; CHP+ Contract 2.1.3

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Colorado Access has an Appeal process available to members and others authorized by the member to voice expressions of dissatisfaction and other requirements by each line of business as outlined in this policy and procedure.[3] COA will provide a written Notice of Adverse Benefit Determination ("Notice") to members or DCRs as described in policy and procedure UM102 Utilization Review Determinations and in accordance with State Medicaid Rules. The Notice includes information on member rights to request an Appeal or State Fair Hearing, and procedures for doing so.

COA will make reasonable effort to provide assistance to a member or DCR in navigating the Appeal process, based on their cultural and linguistic needs, including but not limited to, auxiliary aids and services upon request, completing any necessary Appeal forms, putting oral requests for a State Fair Hearing into writing, and providing interpretive services and toll-free numbers that have TTY/TTD capability when necessary.[4]
COA will not impose any punitive action against a provider who requests for an expedited Appeal or supports a member's Appeal. [5]

At any time during the Appeals process, COA will provide the member and/or DCR upon request with the case file, including any medical records or documents and any new or additional documents considered, relied upon, or generated by COA in connection with the Appeal. This information will be provided free of charge and sufficiently in advance of the Appeal resolution timeframe.[6]

PROCEDURES:

A. Initiating an Appeal

1. Members, DCRs, and the legal representative of a deceased member's estate may request a review of an Adverse Benefit Determination through the Appeal process either verbally or in writing.[7] The appeal process is the same whether the appeal is filed verbally or in writing.
2. A member or DCR must submit an Appeal of the Adverse Benefit Determination

[3] 42 CRF 438.400; RAE Contract 8.7.1; CHP+ Contract 8.6.1
[4] RAE Contract 8.3; CHP+ Contract 8.2
[5] RAE Contract 8.7.12; CHP+ Contract 8.6.12
[6] RAE Contract 8.7.10; CHP+ Contract 8.6.10
[6] RAE Contract 8.7.10; CHP+ Contract 8.6.10
[7] RAE Contract 8.7.6, 8.7.7; CHP+ Contract 8.6.5.2, 8.6.6, 8.6.7

within sixty (60) calendar days from the date of the Notice.[8]

3. Upon receipt of an Appeal, a written acknowledgement of the Appeal is provided to the member or DCR within two (2) business days of receipt, unless the member or DCR requests an expedited resolution.[9]
4. COA will provide the member with reasonable opportunity to present evidence and testimony and make legal and factual arguments (in person or in writing). COA will inform the member of the timeframe required to submit evidence in advance of the corresponding resolution time, especially with the limited timeframe for expedited Appeals. If relevant information is not submitted by the member within the required timeframe, COA will document the missed deadline submission.[10]

B. COA Appeal Review

1. The Clinical Appeal Review Team determines what provider specialty is needed to review the Appeal and communicates that to the appropriate internal and/or external review entity.
2. The review will be performed by a Colorado Access Medical Director who meets the following requirements[11]:
   a. Is not a physician who was involved in the initial determination, nor the subordinate of such physician, for appeals that require medical necessity review[12];
   b. Holds an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States;
   c. Is in the same profession or similar specialty as typically manages the medical condition, procedure, or treatment as determined by the Clinical Appeal Review Team;
   d. Must be present in the United States when performing the Appeal review;
   e. Board certified by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists from

[8] RAE Contract 8.7.5.1; CHP+ Contract 8.6.5.1
[9] 42 CFR 406(b)(1); 10 CCR 2505-10 8.209.5.B;

[11] RAE Contract 8.7.8; CHP+ Contract 8.6.8, 8.6.9
[12] RAE Contract 8.7.4; CHP+ Contract 8.6.4

the major areas of clinical services;

f. Has current, relevant experience and/or knowledge to render a determination specific to the case. The reviewing specialist's training and experience must include treating the condition, include treating complications that may result from the service or procedure, and be sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate. Reviewers will attest that they comply with the above criteria for each Appeal case they accept and will sign an attestation form; and

g. Does not have a direct financial interest in the Appeal or outcome of the Appeal review.

3. A physician may request a peer review as part of the appeal information gathering process. The peer review will be scheduled according to the Appeal Timeframes Section V below.

4. Appeal reviewers:

   a. Document the substance of the appeal including:

      a. The member's reason for appeal the previous decision, additional medical records, and all documentation submitted with the appeal.

      b. The previous denial history.

      c. All follow-up activities associated with the denial that occurred prior to submission of the current appeal.

   b. Fully investigate the content of the appeal and document its findings.

      a. Take into account all submitted written comments, documents, records and other information relating to the case without regard as to whether such information was submitted in the initial consideration of the case.[13]

C. Appeal Determinations

1. Written notice of the Appeal determination will be in a format and language that is easily understood and shall include the result of the disposition and the date it was completed.[14] For Appeals not resolved wholly in favor of the member, the written

[13] RAE Contract 8.6.3; CHP+ Contract 8.6.3
[14] RAE Contract 8.6.2; CHP+ Contract 8.5.2

notice shall also include[15]:

a. The right to request a State Fair Hearing and how to do so;

b. The right to request and to receive benefits while the hearing is pending, and how to make the request;

c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the original Action; and

d. A statement that the clinical rationale used in making the Appeal decision will be provided, in writing, upon request of the member, provider or other ordering provider or facility rendering service.

e. The notice will reference the specific benefit provision, guideline, protocol, or other similar criterion used to make the Appeal decision and will inform the member or DCR that a full copy (or excerpt) of that criterion is available upon request.

f. The notice will identify each individual participating in the appeal review by title (and, for medical necessity reviews, by clinical credentials and specialty).

2. COA has only one level of Appeal for members. If a member disagrees with an Appeal determination, they may file a request for a State Fair Hearing (please reference Section 6).

3. If the Appeal determination overturns COA's Adverse Benefit Determination, thereby reversing a decision to deny, limit or delay services that were not provided while the Appeal was pending, COA shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.[16]

4. If the Appeal determination overturns COA's action to deny authorization of services and the member received the services while the Appeal was pending, COA must authorize and provide (and subsequently pay) for those services as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the Adverse Benefit Determination.[17]

[15] RAE Contract 8.7.14.3; CHP+ Contract 8.6.13.3
[16] RAE Contract 8.7.14.4; CHP+ Contract 8.6.13.6
[17] RAE Contract 8.7.13.4; CHP+ Contract 8.6.13.4

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D. Appeal Timeframes

1. Standard Appeals: A standard Appeal is resolved and written notice of the resolution and the date it was completed is provided to the member or DCR, and the requesting provider within ten (10) business days of receipt. This includes Preservice and Postservice appeals[18]
2. Expedited Appeals: An expedited Appeal can be initiated if COA determines or the requestor indicates that taking the time for a standard resolution would seriously jeopardize the member's life, health, or ability at attain, maintain, or regain maximum function. An expedited Appeal is always granted for requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.
    a. If a request for an expedited Appeal resolution is denied, COA will make a reasonable effort to give the member, or DCR, and the provider prompt verbal notice of the denial and provide written notice to the member or DCR within two (2) calendar days. The Appeal will then follow the process for a standard resolution. The member will be informed of the right to file a grievance if they disagree with COA's decision.[19]
    b. An expedited Appeal is resolved and written notice of the resolution and the date it was completed is provided to the member or DCR within seventy-two (72) hours of receipt.[20]
    c. If the member or DCR wishes to present additional evidence to support allegations of fact or law for an expedited Appeal, this may be done in person or in writing. COA will verbally inform the member or DCR that this evidence must either accompany the request for an expedited Appeal or be received within forty-eight (48) hours of the receipt of the request for an expedited Appeal in order to be considered part of the request for an expedited Appeal.
    d. COA will make reasonable efforts to provide verbal notice of the expedited resolution to the member or DCR representative and the requesting provider.
3. Extensions: COA may extend the time frame up to fourteen (14) calendar days in order to resolve a standard or expedited Appeal if the member or DCR requests the extension, or COA shows a need for additional information and the delay is in

[18] RAE Contract 8.7.13.4
[19] RAE Contract 8.7.14.1.1; CHP+ Contract 8.6.13.1.1
[20] RAE Contract 8.7.14.2.2; 8.7.14.2.5; CHP+ Contract 8.6.13.2.2; 8.6.13.2.5

the member's best interest.[21]

a. If COA extends the timeframe, reasonable efforts will be made to give the member prompt oral notice of the delay and within two (2) calendar days will provide the member or DCR with prior written notice of the reason for the delay and inform the member that they can file a grievance if they do not agree with the timeframe delay.[22]

b. The Appeal will be resolved as expeditiously as the member's condition requires and no later than the date that the extension expires.

E. Continuation of Benefits during the Appeal Process for Medicaid members[23].

1. COA does not typically issue adverse benefit determinations that involve the termination, suspension, or reduction of a previously authorized course of treatment. In the rare event that this occurs, members (and/or the DCR) may request continuation of the previously authorized service by contacting clinical.services@coaccess.com. This continuation of benefits must be requested during the appeal and also during a State Fair Hearing. Note: Providers may not request continuation of benefits on behalf of the member. This process is not applicable to CHP+ HMO members.
2. COA will provide for the continuation of benefits of a previously authorized service while an Appeal is pending (until the end of the approved treatment period or determination of the appeal) when all of the following criteria are present[24]:
   a. The request for continuation of benefits must be filed by a member or DCR in a timely manner, which means on or before the later of:
   b. Within 10 days of COA mailing the notice of Adverse Benefit Determination OR
   c. The intended effective date of the proposed Adverse Benefit Determination.
   d. The Appeal must involve the termination, suspension, or reduction of a previously authorized course of treatment.
   e. The services were ordered by an authorized provider.

[21] RAE Contract 8.7.14.2.3; CHP+ Contract 8.6.13.2.3
[22] RAE Contract 8.7.14.2.4; CHP+ Contract 8.6.13.2.4
[23] RAE Contract 8.7.14.2.5; CHP+ Contract 8.6.13.2.5
[24] RAE Contract 8.7.13

f. The original period covered by the original authorization has not expired.

g. The member requests an Appeal in accordance with the required timeframes.

3. Duration of continued or reinstated services: If at the member's request, COA continues or reinstates the member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs (the end of the authorization period does not apply to when benefits end) [25]:

a. At the tenth day after receiving the Notice of Adverse Benefit Determination, if the member has not filed for continuation of benefits, the benefits are discontinued; or

b. The member withdraws the Appeal; or

c. COA issues an appeal decision adverse to the member and the member fails to request a continuation of benefits during a State Fair Hearing (see section 6 below) within ten calendar days after COA sends the notice of an adverse appeal resolution to the member.

F. External Secondary Review for Inpatient and Residential Substance Use Disorder Treatments:

1. Pursuant of C.R.S 25.5-5-423, an external medical review may be requested when there is a denial or reduction for residential or inpatient substance use disorder treatment and the appeals process have been exhausted.
2. Members should email their name and contact information to HCPF_SUDreviewrequest@state.co.us. The member will be contacted for more information and the name of their SUD provider. The identified provider will then be contacted with instructions on how to formally request the secondary SUD review.
3. If requested by the Department and external secondary review organization, RAEs and MCOs must provide a point of contact and member original medical records from the initial denial available for the independent review organization to make the determination.
   a. The point of contact for COA will be the Director of UM. The process can be initiated by emailing behavioral.health@coaccess.com.

G. State Fair Hearing[26]:

1. Members must file an Appeal with COA first and receive a decision that they do not

[25] RAE Contract 8.7.13.1
[26] RAE Contract 8.7.13.2

agree with before making a request for a State Fair Hearing. A State Fair Hearing may be requested within 120 calendar days from the date on the COA Appeal outcome letter.[27]

2. Members may request a State Fair Hearing if COA fails to meet any timelines related to the Adverse Benefit Determination or fails to adhere to the notice and timing requirements for extension of the Appeal resolution time frame.[28]
3. COA will participate in all Appeals-related State Fair Hearings. Participants will also include the member, his/her representative, and/or the representative of the member's estate.[29]
4. COA informs members of their right to a State Fair Hearing and how to request one primarily through the member's 1) Notice and 2) the Appeal resolution letter. COA also includes information about this avenue for resolving an Appeal in other written member materials such as the Member Handbook, the EOC and the member section of the COA website. COA will provide reasonable assistance to a member, or DCR in requesting a State Fair Hearing including, but not limited to, putting oral requests for a State Fair Hearing into writing, and providing access to interpretive services and toll-free numbers with TTY/TDD capability.
5. If the State Fair Hearing determination overturns COA's action to deny authorization of services and the member received the services while the Appeal was pending, COA must authorize and provide (and subsequently pay) for those services as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.[30]

H. Continuation of Benefits during the State Fair Hearing process for Medicaid members[31].

1. COA does not typically issue adverse benefit determinations that involve the termination, suspension, or reduction of a previously authorized course of treatment. In the rare event that this occurs, members (and/or the DCR) may request continuation of the previously authorized service by contacting clinical.services@coaccess.com. This continuation of benefits must be requested

[27] RAE Contract 8.7.15; CHP+ Contract 8.6.14
[28] RAE Contract 8.7.15.1.1; CHP+ Contract 8.6.14.1.1
[29] RAE Contract 8.7.15.2; CHP+ Contract 8.6.14.2
[30] RAE Contract 8.7.15.3; CHP+ Contract 8.6.14.3
[31] RAE Contract 8.7.13.4; CHP+ Contract 8.6.14.4

during the appeal and also during a State Fair Hearing. Note: Providers may not request continuation of benefits on behalf of the member. This process is not applicable to CHP+ HMO members.

2. COA will provide for the continuation of benefits of a previously authorized service while a State Fair Hearing is pending when all of the following criteria are present[32]:
   a. The request for continuation of benefits must be filed by a member or DCR within 10 days following the notice of the adverse appeal resolution (the notice that the appeal is upholding the initial adverse benefit determination).
   b. The State Fair Hearing must involve the termination, suspension, or reduction of a previously authorized course of treatment.
   c. The services were ordered by an authorized provider.
   d. The member requests a State Fair Hearing in accordance with the required timeframes.

3. Duration of continued or reinstated benefits: If at the member's request, COA continues or reinstates the member's benefits while the State Fair Hearing is pending, the benefits must be continued until one of the following occurs[33]:
   a. The member withdraws the request for a State Fair Hearing; or
   b. A State Fair Hearing officer issues a decision adverse to the member.

I. Reporting and Record Maintenance[34]:

1. COA will accurately maintain records of member Appeals in a manner that is accessible to the state and available upon request to any oversight body. Appeals will be reported in aggregate and detailed form as specified and required by the Centers for Medicare and Medicaid Services (CMS), State Division of Insurance (DOI) Regulations and contractual requirements.

2. All records will maintain all elements of the Appeal, including but not limited to:
   a. The patient's name, provider name, and/or the facility rendering service.
   b. A general description of the reason for the Appeal.
   c. Copies of correspondence from the patient, provider or facility rendering the service and Colorado Access regarding the Appeal.
   d. Dates the Appeal was received, the date of each Appeal review, dates of any review meetings, and date of resolution;

[32] RAE Contract 8.7.13.

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e. Documentation of actions taken (previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal) and the final resolution); and
f. Substance of the appeal (the member's reason for appealing the previous decision and any additional clinical or other information provided with the appeal request); and
g. Minutes or transcripts of Appeal proceedings.

3. The file will also include the signed attestation form of the clinical peer reviewer which contains the name, credentials and indicates that the individual meets the qualifications.

4. COA provides Appeal reports to the appropriate COA committee(s) or department(s) to evaluate overall health plan efficiencies and identify opportunities for improvement.

5. Appeals oversight: a random sample of appeals are reviewed each month to assure compliance with appeal turnaround times, reviewer requirements, and appeal resolution letter requirements. Appeal reporting is provided to the Department of Health Care Policy and Financing on a quarterly basis. Trends or patterns in appeals are continually monitored and addressed as needed.

REFERENCES:
ADM203 Member Grievance Process
UM102 Utilization Review Determinations

ATTACHMENTS: None

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
Version 1: 9/15/21, Version 2: 11/01/22, Version 3: 5/01/23, Version 4: 11/17/23, Version 5: 03/20/24, Version 6: 05/22/2, Version 7: 11/21/2024, Version 8: 10/23/25 Annual Review. NCQA updates. Version 9: 05/07/2026 NCQA updates. Appeal process updates: adds "upon request" case-file access, tightens reviewer requirements, and expands expedited-appeal criteria.

APPROVAL BODY: COA Core Policy Team **APPROVAL DATE:** 05/07/2026