

The Patient Self-Advocacy Guide was prepared by the National Multiple Sclerosis Society, Colorado-Wyoming Chapter

HELPING YOURSELF IS JOB #1



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PREFACE

Managing your health care when you have been diagnosed with a chronic disease can be challenging and confusing. Empowering yourself to act on your own behalf can make a world of difference. This guide is designed to help you navigate through some of the most important issues in managing your own health care.

What is self-advocacy and why does it matter?

When it comes to your health care, the person who can best ensure that you receive the highest quality, affordable care is you. In order to effectively advocate for yourself, you must be able to openly communicate your needs, interests, and rights.

***Don't be afraid to ask questions and take notes!
Whenever you don't understand something, speak up.***

If you are confused about costs, want to find out about alternative treatments, or want more information, you have the right to ask questions and receive clear answers. Be informed; do research online, ask questions, and know what your options are before making decisions. Find out what the alternatives are. Hold on to records and receipts.

This guide can help you understand how to advocate for yourself when it comes to your health care and medical costs. Empower yourself by being your own advocate.

Your healthcare is of the utmost importance. This guide can help you get the best value and better care out of your health care.

CHOOSING

YOUR HEALTH INSURANCE PLAN

With the initiation of the Affordable Care Act (Obamacare) this fall, there are many more options that are open to you when it comes to health insurance coverage. Health insurers are now required to provide a Summary of Benefits and Coverage (SBC) for every policy that they offer. They must also offer a glossary of medical terms used so that their policies are easier to understand.

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HOW DO I CHOOSE THE RIGHT HEALTH INSURANCE PLAN?

You have a few different options for getting financial assistance with your health care, depending on what your income is.

MEDICAID In Colorado, all individuals under 65 years of age with income below 133% of the Federal Poverty Level (FPL) will be eligible. In Wyoming, individuals must make under 100% of FPL (see chart below¹). Recipients must meet citizenship requirements and must not be incarcerated. You can check your eligibility and register at the [Colorado PEAK website](http://coloradopeak.force.com/)².

MEDICARE You are eligible for Medicare if you are over 65 years old, or if you are under 65 and receive Social Security benefits. You may be eligible if you have a disability. For more details on Medicare eligibility, find and contact your [local Social Security Office](https://secure.ssa.gov/ICON/main.jsp)³. You can also call 1-800-772-1213.

CONNECT FOR HEALTH COLORADO This is the new health insurance marketplace in Colorado. Any individual living in Colorado and who needs health insurance may use it to shop for health plans. If you are buying insurance and make less than 400% of FPL (see chart below), you will be eligible for the Advanced Premium Tax Credit (APTC). Shop for plans and check your eligibility for the APTC at the Connect for Health website at www.connectforhealthco.com.

HEALTH INSURANCE MARKETPLACE (WYOMING) This is the new health insurance marketplace in Wyoming. This marketplace also has an Advanced Premium Tax Credit (APTC) available to consumers who make less than 400% of FPL. Shop for plans and check your eligibility on the marketplace's website at www.healthcare.gov.

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FAMILY SIZE	100% FPL	133% FPL (Medicaid eligibility limit)	250% FPL (HPAP eligibility limit)	400% FPL (APTC eligibility limit)
1	\$11,490	\$15,282	\$28,725	\$45,960
2	\$15,510	\$20,628	\$38,775	\$62,040
3	\$19,530	\$25,975	\$48,825	\$78,120
4	\$23,550	\$31,322	\$58,875	\$94,200
5	\$27,570	\$36,668	\$68,925	\$110,280
For each additional person add:	\$4,020	\$5,347	\$10,050	\$16,080

¹ [2013 Federal Poverty Guidelines](http://www.dhs.gov/2013-federal-poverty-guidelines)

² <http://coloradopeak.force.com/>

³ <https://secure.ssa.gov/ICON/main.jsp>

Additionally, when shopping for health insurance, find out what prescription medications are included in the plan's formulary and if it covers the medication you need or are currently taking. This information can be found on the Summary of Benefits and Coverage or through calling the toll-free number of the insurance company.

Look at all of your potential costs in a health plan, and not just the premium. A good rule of thumb about your costs in a health plan is the higher the monthly premium, the greater the coverage you receive and the lower the copayments and/or co-insurance when you use the insurance; the lower your monthly premium, the less coverage you receive and the higher the costs to you when you use the insurance.

Examine the list of network providers of any health plan you are considering, and don't hesitate to ask for verification as these lists can change frequently. To be an "in-network provider" means the provider has agreed to the plan's pre-negotiated payment rate. It may be necessary to use out-of-network provider(s) for certain needs from time to time, but it is best to know in advance whether a provider is 'inside' or 'outside' of your network so you can plan accordingly.



NEGOTIATING

COSTS AT YOUR DOCTOR'S OFFICE

Contrary to what you may believe, many aspects of your healthcare are negotiable. Knowledge is power, and the more you know and the more proactive you become, the better prepared you will be to manage your care within your means. Doctors, prescriptions and even hospital bills are to a large extent negotiable. This guide will explain what some of your options are and how to achieve the best outcome.

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GETTING YOUR DOCTORS TO CARE ABOUT YOUR HEALTH CARE COSTS

Your doctor is the conduit to many facets of your individualized care and the associated costs for such care. What follows is a discussion of how to approach your doctor(s) about cost, when to optimally do so, how to prepare and what you can expect.

How to negotiate costs at your doctor's office

Your doctor is the first person you will go to when you need health services. He or she is the person who helps you decide on your course of treatment and therefore plays a huge role in determining what your bills will look like. Your doctor is obligated to take your financial resources into account when providing care, so it is helpful to have an open and honest relationship concerning your medical costs. If you let your doctor know, even before any costs are incurred, that managing your bills is important to you, he or she may be able to come up with much more affordable options. For example, prescribing generic instead of brand-name drugs may save you a considerable amount of money without compromising the quality of your healthcare.



When should I talk to my doctor?

There is no right or wrong time to talk to your doctor about costs. However, the earlier you can let your doctor know that managing your medical bills is important to you, the better. Your doctor may be able to suggest cost-saving practices before any costs have even been incurred. It is also a good idea to bring it up early in your visit to ensure that you have enough time, as doctors often have tight schedules. You might ask cost related questions over the phone before you've scheduled your appointment; that way you can go in knowing that plan is accepted or that you will be receiving a self-pay discount.

What if my doctor says that someone else in the office handles billing?

Often it is the administrative staff or billing department that handles the billing and insurance. Your doctor may not know specific prices or insurance policies. However, since it is your doctor who orders services and who can suggest alternative treatments or medications, it is still important to let him or her know that cost is an important consideration for you. Make sure your doctor knows if you are paying out of pocket and that you ask for a self-pay discount, or if you have a high deductible. They may be able to give you a discount comparable to what they would charge insurance companies – but only if you ask!

The person who handles the office's billing will be the person who ensures that services get paid for. That will be the person who knows the exact pricing of various services and may also be the person to talk to about setting up a payment plan, if necessary. Write down that person's name and phone number! They may be your new best friend when it comes to understanding your payment options.

What can I do to prepare to talk to my doctor about costs?

Contact your insurance carrier to find out exactly what services and medications they cover and what your deductibles and co-pays are. Know what treatments or types of medications you need and research average prices. Many insurance companies list average prices for various treatments, tests and procedures online.

Ask your provider for billing codes for any services you need. The codes are called CPT codes for doctor's office visits and DRG codes for hospital treatments. [Healthcarebluebook.com](http://healthcarebluebook.com) and the [All Payer Claims Database](#)⁴ are good resources to find out average prices of healthcare services in your area. You can also contact alternate facilities that offer the service and see how their prices vary. Alternate providers can be found on your health insurer's website or on the AMA (American Medical Association) website ([AMA Physician Locator Tool](#)⁵).

How do I negotiate for a lower price?

If the price your provider is charging is much higher than the Blue Book price or the price at other local facilities, talk to your doctor about it. Ask for a rate that is more comparable to what you have found in your research. You can cite Health Care Blue Book as a standard and ask if your doctor will accept that price. Remind your doctor that you are paying out of pocket, if that is the case.

Make sure you document your agreement. Ask the provider's office to give you a written verification of the price or to send it to you by mail or e-mail. There is a Health Care Blue Book Pricing Agreement that you can print out and have the provider sign. [Here](#)⁶ is an example of the pricing agreement for an arm MRI.

Can I negotiate the price if I've already received the treatment?

Yes, you can. Look up the price on Health Care Blue Book or find out what other providers are charging. Then contact your doctor and ask to speak with the billing department or office manager. If you don't have insurance, let them know that you are a self-pay patient and would like to inquire about a discount. If you have low income, let them know and find out if they have any kind of financial assistance programs.

You may use the Health Care Blue Book price as a reference when speaking with the provider. If the person you are speaking with cannot discount your bill, ask to speak to someone at a higher level or if they can ask their manager for you. Make sure to get any agreement in writing. There is a Health Care Blue Book Pricing Agreement that you can have the provider sign.

TOP COST RELATED QUESTIONS TO ASK YOUR DOCTOR:

1. How much is my co-pay?
2. Do I have to pay my co-pay today or can you bill me?
3. If I have questions about my bill, who do I speak to?
4. Will I need to get any particular test done because I have these symptoms? If so, how much will it cost?
5. Do I need a referral to see a specialist? What cost can I possibly incur from meeting with a specialist?

⁴ Keep in mind that the Colorado APCD is a work in progress. The URL is <http://www.cohealthdata.org/#/home>.

⁵ <https://extapps.ama-assn.org/doctorfinder/home.jsp>

⁶ [http://healthcarebluebook.com/page_PricingAgreement.aspx?PA_Type=MD&PA_Price=\\$553&PA_Name=Arm%20MRI%20-%20\(no%20contrast\)&PA_Desc=Price%20includes%20the%20total%20amount%20for%20both%20physician%20\(interpretation\)%20and%20technical%20\(imaging\)%20fees.%20%252](http://healthcarebluebook.com/page_PricingAgreement.aspx?PA_Type=MD&PA_Price=$553&PA_Name=Arm%20MRI%20-%20(no%20contrast)&PA_Desc=Price%20includes%20the%20total%20amount%20for%20both%20physician%20(interpretation)%20and%20technical%20(imaging)%20fees.%20%252)

IS THE COST OF YOUR

PRESCRIPTIONS

HARD TO SWALLOW?

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First, always find out if there are patient assistance programs before starting any new medications. There are often assistance programs run by drug companies or nonprofit organizations. Contact the drug company to see what kind of programs they offer and if you are eligible. You will have to fill out an application, which will usually be available on the drug company's website.

A list of pharmaceutical assistance programs by state can be found [here](#).

(In Colorado, the program only serves people diagnosed with AIDS/HIV).

Drug discount cards may also be available to help with the cost of your prescriptions. Some are free and some have a monthly fee. Be sure to thoroughly research the program that is offering the discount card, as there are scams out there that just want your credit card number and Social Security number. Look for terms of service and a 30-day refund policy. Listed below are a few sites that provide information and listings of prescription assistance programs:

- [Partnership for Prescription Assistance](#)
- [NeedyMeds](#) (offers a free drug discount card)
- [RxAssist](#)
- [National Council on Aging's Center for Benefits](#)
- [RxOutreach](#) (a mail order pharmacy for people with little or no health insurance)

It is a good idea to review your prescriptions with your doctor somewhat regularly. Make sure that all of your medications are still necessary. If they are necessary, ask if there is any alternative that costs less. It will be helpful to know the specifics of your co-pays; are there differences in cost between a three-month prescription and a monthly prescription? Knowing these details about your insurance coverage can help save you money.

TOP QUESTIONS

TO ASK ABOUT YOUR PRESCRIPTION MEDICATION COSTS:

1. Is there a patient assistance program to help pay for my prescriptions?
2. The discount prescription application is confusing. Is there any assistance available to help me understand it?
3. My doctor prescribed me this medication; will it interfere with the other prescriptions I am taking?
4. Can I get this prescription in the generic form?

NEGOTIATING

HOSPITAL COSTS

Contrary to what you may believe, many aspects of your healthcare are negotiable. Knowledge is power, and the more you know and the more proactive you become, the better prepared you will be to manage your care within your means. Doctors, prescriptions and even hospital bills are to a large extent negotiable. This guide will explain what some of your options are and how to achieve the best outcome.

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HOSPITAL COSTS CAN REALLY MAKE YOU SICK

Knowing how to negotiate lower hospital costs and extended payment plans can make a huge difference. Read this section carefully and learn how to negotiate hospital costs on your own behalf.

Who should I talk to about my hospital bills?

Ask your doctor or service provider about ways to manage costs. They may be able to refer you to a financial assistance office in the hospital or even suggest more cost-efficient alternative treatments. More important than whom you ask is that you ask at all. Many hospitals have financial assistance programs, but they need to know that you are interested in them in order to help.

When should I talk to my doctor or service provider?

It is best to start thinking about costs before the procedure or service has been provided. Talk to your doctor or service provider as early as you can. That being said, there is no right or wrong time to bring up costs with your doctor. He or she is obligated to take your financial resources into account when providing care, so it is helpful to have an open and honest relationship concerning your medical costs, no matter what stage of the game you are in.

What can I do to prepare to talk to my doctor about costs?

Know your rights! **The Hospital Payment Assistance Program**, a law passed in 2012, requires hospitals to provide you with clear and complete information regarding the available discount programs, charity care, and payment plan policies. The information should be in hospital waiting rooms and on hospital websites, as well as included with your bill. If you have not yet received information on these resources, you can always ask the hospital directly. Also ask about charity care. Many hospitals provide free care to people who make under a certain income level.

The Hospital Payment Assistance Program also requires hospitals to establish a discount program for all uninsured patients who make less than 250% of FPL (Federal Poverty Level). Check the chart on page 4 for current FPL levels.

Your hospital should automatically offer to screen you for the discount program, charity programs, or other financial assistance services that the hospital may have if you are uninsured (if you are not sure if you've been screened, ask!).

Can I set up a payment plan?

Yes, you can. If you are uninsured, the hospital must offer you a reasonable payment plan and cannot initiate collection proceedings within thirty days of the first missed payment.

Does my hospital status matter?

Yes, it is important to know what your status at the hospital is. The coverage your insurance carrier will provide may differ depending on whether your status is "admitted" or "under observation." Also be aware that your status can change from day to day, so ask often.

How can I research costs for different procedures and services?

Contact your insurance carrier to find out exactly what services and medications they cover and what your deductibles are. Know what treatments or types of medications you need and research average prices. Many insurance companies list average prices for various treatments, tests and procedures online.

If possible, ask your provider for billing codes for any services you need. The codes are called CPT codes for doctor's office visits and DRG codes for hospital treatments.

Healthcarebluebook.com is a good resource to find out average prices of healthcare services in your area. You can also contact alternate facilities that offer the service and see how their prices vary. Prices for identical procedures at different hospitals often vary widely, so make sure to check at least 3 different facilities before choosing where you go. Alternate providers can be found on your health insurer's website or on the AMA (American Medical Association) website.

The Centers for Medicare and Medicaid website (www.cms.gov) can also be a helpful resource. It lists the 100 most common inpatient charges and 30 most common outpatient services, average covered charges, and average total payments.

How do I ask for a lower price?

Find out who is in charge of billing at the hospital. It may be a billing department or an administrative staff person. If the price you are charged is much higher than the Blue Book price or the price at other local facilities, talk to them about it. Ask for a rate that is more comparable to what you have found in your research. You can cite Health Care Blue Book as a standard and ask if your doctor will accept that price. Remind them that you are paying out of pocket, if that is the case.

Make sure you document your agreement. Ask the provider's office to give you a written verification of the price, or to send it to you by mail or e-mail. There is a Health Care Blue Book Pricing Agreement that you can have the provider sign.



What can I do to lower my hospital bills when I've already received treatment?

First, always thoroughly review your bill for clerical errors (you may have to specifically ask for an itemized bill). Make sure there are no double charges or treatments that you did not receive. It is okay to ask to go over the bill with your provider if you have questions.

Once you determine that your bill is correct, negotiating your bill will be similar to how you would do it before the costs were incurred. Talk to your providers and hospital administrators to see what kind of payment assistance programs or discounts they offer. Be sure to let them know that you are paying out of pocket, if that is the case. Research standard prices on healthcarebluebook.com and at other facilities in your area.

TOP QUESTIONS

TO ASK ABOUT YOUR HOSPITAL COSTS:

1. What is my deductible? Do I need to pay any upfront cost for the procedure?
2. Do all hospitals charge the same amount for the same type of procedure?
3. Which hospital charges the least amount for this type of surgery?
4. Is this a procedure that can be performed as outpatient treatment instead of hospitalization?
5. Will this procedure need to be followed up by any additional procedures? If yes, what will be the total cost associated with my condition be? How many follow-up appointments will I need after surgery?

NEGOTIATING

IMAGING COSTS

Contrary to what you may believe, many aspects of your healthcare are negotiable. Knowledge is power, and the more you know and the more proactive you become, the better prepared you will be to manage your care within your means. Doctors, prescriptions and even hospital bills are to a large extent negotiable. This guide will explain what some of your options are and how to achieve the best outcome.

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IMAGING COSTS SHOULDN'T BE HARD TO IMAGINE *(MRIs, CAT Scans, X-Rays, Mammography, etc.)*

Where can I find affordable imaging procedures?

Contact your insurance carrier to see what types of imaging they will cover and if you have a deductible or co-pay. Next, research average costs for imaging procedures online. Healthcarebluebook.com lists average prices for specific procedures, as well as cost-saving tips and fair pricing information. You can also contact alternate facilities that offer the service and see how their prices vary. Alternate providers can be found on your health insurer's website or on the AMA (American Medical Association) website ([AMA Physician Locator Tool](#)⁷). Contact several different facilities to compare prices before making a decision.

How do I ask for a lower price?

If the price your facility is charging is much higher than the Blue Book price or the price at other local facilities, talk to your doctor about it. Ask for a rate that is more comparable to what you have found in your research. You can cite Health Care Blue Book as a standard and ask if your doctor will accept that price. Remind your doctor that you are paying out of pocket, if that is the case.

Make sure you document your agreement. Ask the provider's office to give you a written verification of the price, or to send it to you by mail or e-mail. There is a Health Care Blue Book Pricing Agreement that you can print out and have the provider sign. [Here](#) is an example of the pricing agreement for an arm MRI⁸.

TOP QUESTIONS TO ASK ABOUT YOUR IMAGING COSTS:

1. What portion of my insurance will pay for this x-ray/image?
2. Will I have to pay any out-of-pocket cost for my x-ray/image?
3. Does my insurance stipulate how often I can have this particular type of image? For example, will they cover this type of image at 100% every three years, every two years, or however often I need it done? Is this a procedure that can be performed as outpatient treatment instead of hospitalization?
4. Can I get a copy of my images from my imaging session? Will I have to pay for the images if I want them?
5. Do all diagnostic centers charge the same price for their tests and x-rays?

⁷ <https://extapps.ama-assn.org/doctorfinder/home.jsp>

⁸ [http://healthcarebluebook.com/page_PricingAgreement.aspx?PA_Type=MD&PA_Price=\\$553&PA_Name=Arm%20MRI%20-%20\(no%20contrast\)&PA_Desc=Price%20includes%20the%20total%20amount%20for%20both%20physician%20\(interpretation\)%20and%20technical%20\(imaging\)%20fees.%20%252](http://healthcarebluebook.com/page_PricingAgreement.aspx?PA_Type=MD&PA_Price=$553&PA_Name=Arm%20MRI%20-%20(no%20contrast)&PA_Desc=Price%20includes%20the%20total%20amount%20for%20both%20physician%20(interpretation)%20and%20technical%20(imaging)%20fees.%20%252)

HOW TO FILE

COMPLAINTS

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HOW DO I FILE A COMPLAINT AGAINST AN INSURER?

If you feel that your insurer has acted inappropriately or failed to fulfill your policy, you may file a complaint with the Division of Insurance. To file a complaint, fill out the [Request for Assistance Form](#)⁹ on the Division of Insurance website. (Find the Wyoming Request for Assistance Form [here](#).¹⁰)

In Colorado, you may also submit a complaint by fax (303-894-7455) or mail a letter to:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202-4910

Find more information at the [Colorado Division of Insurance website](#)¹¹ or the [Wyoming Division of Insurance website](#).¹²

HOW DO I FILE A COMPLAINT AGAINST A PROVIDER?

In the state of Colorado, if you feel that your provider has done something inconsistent with the laws and regulations governing medical care, you may file a complaint with DORA, the Department of Regulatory Agencies.

In the state of Wyoming, you may file a complaint against a medical provider with the State of Wyoming Board of Medicine. First, you must submit a written complaint which must include the name of the physician or physician's assistant involved, the patient's name, and a detailed narrative describing the incident. The complainant's name, address, and phone number must also be included. A [complaint form](#)¹³ can be found on the Board of Medicine website. The President and Secretary of the Board will review your complaint within 30 days of its submission.

(There is more information at the [Colorado Division of Professions and Occupations website](#)¹⁴, or the [Wyoming Board of Medicine website](#).¹⁵)

⁹ http://www.dora.state.co.us/pls/real/Ins_Complaint.Submit_Form

¹⁰ <https://sites.google.com/a/wyo.gov/doi/consumers/consumer-request-for-assistance/file-a-complaint/consumer-request-for-assistance-form>

¹¹ <http://cdn.colorado.gov/cs/Satellite/DORA-DI/CBON/DORA/1251631140623>

¹² <https://sites.google.com/a/wyo.gov/doi/consumers/consumer-request-for-assistance/file-a-complaint>

¹³ <http://wyomedboard.state.wy.us/PDF/complaintprocess/ComplaintForm.pdf>

¹⁴ <http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632503133>

¹⁵ <http://wyomedboard.state.wy.us/complaintprocess.aspx>

WHAT CAN YOU DO WHEN YOUR
HEALTH INSURANCE CARRIER

REFUSES A REQUEST

FOR COVERAGE?

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*HEALTH
INSURANCE*

SEE THE FULL GUIDE:

["When Your Health Insurance Carrier Says No; Your Rights Regarding Insurance Pre-Authorization and Grievance Procedures."](#)¹⁶

When you or your health care provider request that a treatment or service be authorized by your insurance carrier, the carrier will perform a "prospective review." The carrier must notify you and your provider of its decision within 15 days of the request.

If you submit a claim for services after they've already occurred, your insurance carrier will perform a "retrospective review." They must notify you and your provider of their decision within 30 days of the request.

If you need a treatment or service within a short period of time, your provider can submit an "urgent care request," and the insurance carrier would have to notify you of its decision in a shorter amount of time. This is called an expedited utilization review.

The prospective, retrospective, and expedited utilization reviews are conducted in order for the insurance company to verify that the treatment or services are medically necessary, appropriate, efficient, or effective. The decision to deny a covered benefit that you and your doctor feel is medically necessary, or you have medical evidence showing that the services aren't subject to a contractual exclusion, is called an "adverse determination."

You have the right to appeal any adverse determinations.

What do I do if I receive an adverse determination?

You have the right to appeal any decision that you are not happy with. All insurance companies have written procedures for how their appeal process works. You can always check your policy or call your carrier to find out what their procedure is. Appeal requests are time sensitive, so it is important to stay on top of it!

Make sure to check all mail you receive from your insurance carrier promptly. If you wait too long, you may lose the opportunity to appeal.



¹⁶<http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadvalue1=in-line%3B+filename%3D%22When+Your+Health+Insurance+Carrier+Says+No.pdf%22&blobheadvalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251814974934&ssbinary=true>

The following are the basic steps to follow when appealing a decision from your health-insurance carrier:

- **Peer-to-peer conversations** – this is your first option, although it is not a necessary prerequisite to filing an official appeal. Have your provider request a peer-to-peer conversation with the person who made the adverse determination on behalf of the insurance company. The conversation must take place within 5 days of when your provider requests it. Sometimes this conversation can help to resolve the issue or to ensure that you understand the decision.
- **First-level review** – to request a first-level review, you must submit the request, usually in writing, within 180 days of receiving the denial. You will not attend this review, but you may submit materials you feel will be helpful, such as written comments, documents, or records. You will be notified of the decision within 30 days of the review.
- **Voluntary second-level review** – you have the right to request a second-level review if you are not satisfied with the result of the first-level review. You must request it within 30 days of receiving the result of the first-level review. It must be scheduled within 60 days of your request, and you will be notified in writing at least 20 days in advance of the review date. You are allowed to attend this review and present additional comments or documents. You and your insurance carrier are both allowed to have attorneys present. You will be notified of the decision within 7 days of the review.
- **Expedited appeal review** – you or your health care provider may request an expedited review when you receive an adverse determination for an urgent care request or for emergency services if you have not been discharged from a facility. You will not attend this review, but you may submit materials you feel will be helpful, such as written comments, documents, or records. You will be notified of the decision within 72 hours of your request. If you receive notification orally, you must also receive written notice within 3 days of the oral notification.
- **Independent external review** – if you are still dissatisfied after the first and second-level reviews, you may have the option to request an external review. There will be instructions on how to request an external review included on the denial letter from your insurance carrier.
- **Medicare and Medicaid** – Medicare and Medicaid have different appeals processes than what is described here. Make sure to read thoroughly any denial letters you receive, as they will have instructions and deadlines pertaining to your appeal. For more information about Medicare’s appeal rules, call the Senior Health Insurance Assistance Program (SHIP) at 888-696-7213. For more information on Medicaid appeal rules, call 303-866-3513 or 800-221-3943.

HOW CAN I ACCESS MY

RECORDS

Whatever the reason you need a copy of your medical records, with few exceptions you are entitled to them. Follow these recommendations when you find it difficult to access your own records.

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YOUR MEDICAL RECORDS ARE YOURS

How can I access my medical records?

“The Privacy Rule gives you, with few exceptions, the right to inspect, review, and receive a copy of your medical records and billing records that are held by health plans and health care providers covered by the Privacy Rule.” (There is more information at the [US Department of Health and Human Services website](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/medicalrecords.html).¹⁷)

Access

Only you or your personal representative has the right to access your records. A health care provider or health plan may send copies of your records to another provider or health plan as needed for treatment or payment or as authorized by you by signing the HIPAA form. However, the Privacy Rule does not require the health care provider or health plan to share information with other providers or plans.

Charges

A provider cannot deny you a copy of your records because you have not paid for the services you have received. Even so, a provider may charge for the reasonable costs of copying and mailing the records. The provider cannot charge you a fee for searching for or retrieving your records.

Provider’s Psychotherapy Notes

You do not have the right to access a provider’s psychotherapy notes. Psychotherapy notes are notes taken by a mental health professional during a conversation with the patient and are kept separate from the patient’s medical and billing records. The Privacy Rule also does not permit the provider to make most disclosures of psychotherapy notes about you without your authorization.

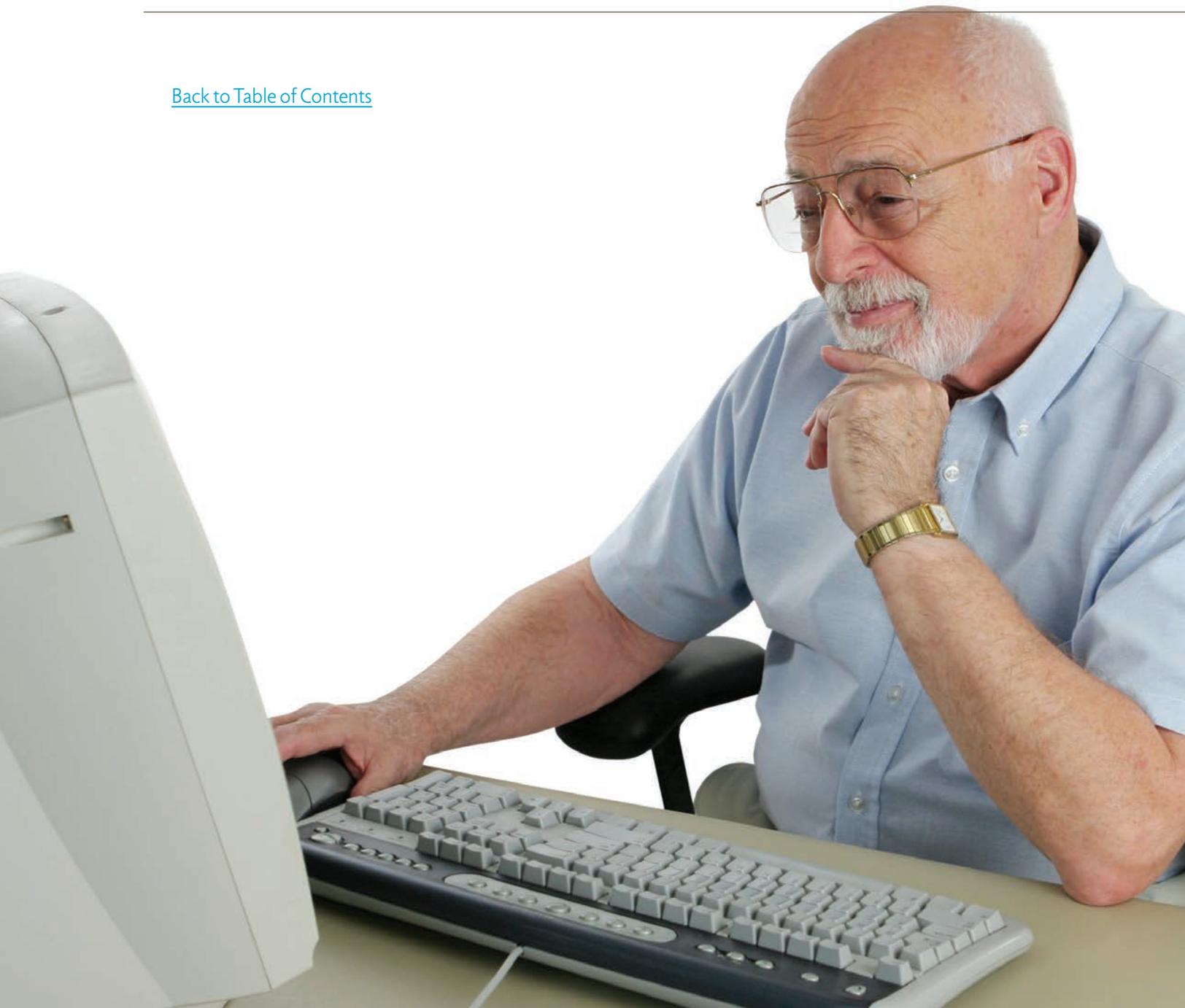
Correcting information

If you think the information in your medical or billing record is incorrect, you can request that the health care provider or health plan amend the record. The health care provider or health plan must respond to your request. If it created the information, it must amend the information if it is inaccurate or incomplete. If the provider or plan does not agree to your request, you have the right to submit a statement of disagreement that the provider or plan must add to your record.

¹⁷<http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/medicalrecords.html>

RESOURCES

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IN COLORADO

Connect for Health Colorado – www.connectforhealthco.com

Colorado PEAK – www.colorado.gov/PEAK

CCHI’s Blue Guide – an online guide to local resources for uninsured and underinsured Coloradans (<http://blueguide.cohealthinitiative.org/>)

Here’s a list of free, low-cost, or sliding-scale clinics in the state of Colorado, provided by NeedyMeds (http://www.needymeds.org/free_clinics.taf?_function=list&state=co)

Health Resources and Services Administration provides a database of low-cost health centers (http://findahealthcenter.hrsa.gov/Search_HCC.aspx)

Tri-County Health Department serves residents of Adams, Arapahoe, and Douglas Counties. They have locations throughout those three counties. (<http://www.tchd.org/index.html>)

[Clinica Colorado](http://www.clinicacolorado.org/) provides medical services to uninsured people. They are located in Westminster, Colorado. You can schedule an appointment by calling 720-443-8461. (<http://www.clinicacolorado.org/>)

[HealthSET](http://www.healthset.org/default.cfm?id=1) is located in Denver and assists low-income elderly people in need of medical services. They can be contacted by calling 720-321-9320. (<http://www.healthset.org/default.cfm?id=1>)

IN WYOMING

Here is a list of free, low-cost, or sliding-scale clinics in the state of Wyoming, provided by NeedyMeds (http://www.needymeds.org/free_clinics.taf?_function=list&state=wy)

[Health Resources and Services Administration](http://findahealthcenter.hrsa.gov/Search_HCC.aspxf) provides a database of low-cost health centers (http://findahealthcenter.hrsa.gov/Search_HCC.aspxf)

[Free clinic directory](http://freeclinicdirectory.org/wyoming_care.html) for Wyoming (http://freeclinicdirectory.org/wyoming_care.html)

OTHER RESOURCES

CoPIRG’s “The Young Person’s Guide to Health Insurance” (<http://copirg.org/sites/pirg/files/resources/HealthCareGuide.pdf>)

GLOSSARY

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ALLOWED AMOUNT Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your health care provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

ACTUARIAL VALUE The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

ANNUAL HOUSEHOLD INCOME The total income for a family in a calendar year.

ANNUAL LIMIT A cap on the benefits your insurance company will pay in a year while you’re enrolled in a particular health insurance plan. Caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

APPEAL A request for your health insurer or plan to review a decision or a grievance again.

BALANCE BILLING When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider, one that is participating in your insurance company’s provider network, may not balance bill you for covered services.

BENEFITS The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan’s coverage documents.

CARE COORDINATION The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

CATASTROPHIC PLAN Health plans that provide coverage for only high-cost services, such as a medical catastrophe, or when medical costs exceed a very high deductible. Connect for Health Colorado will provide a high-deductible plan for young adults called the Colorado Young Adult (CYA) Plan. This type of plan, called the Cover Your Assets (CYA) Plan, will also be available for certain Coloradans with low incomes.

CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) An insurance program jointly funded by states and the federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. In Colorado, this program is called Child Health Plan Plus.

CHRONIC DISEASE MANAGEMENT An integrated care approach to managing illness that includes screenings, checkups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

CLAIM A request for payment that you or your health care provider submits to your health insurer after you receive items or services you think are covered.

COBRA A federal law that may allow you to temporarily keep health coverage after your employment ends, after you lose coverage as a dependent of the covered employee, or as a result of another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

CO-INSURANCE A kind of cost-sharing in which the insurance company pays for a percentage of the cost of medical treatment, and the patient pays the rest. This is separate from deductibles and premiums. For example, if the health insurance or plan’s allowed amount for an office visit is \$100 and you’ve met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

CO-PAY A fixed amount (for example, \$15) you pay for a medical visit or for medication that is covered under your health plan, usually when you receive the service. This is considered part of your out-of-pocket costs, separate from premiums and deductibles.

COST SHARING The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn’t include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

DEDUCTIBLE The amount you must pay for health care services before your health insurance company will start paying benefits. For example, if your deductible is \$1,000, your plan won’t pay anything until you’ve met your deductible for covered health care services that are subject to the deductible. The deductible may not apply to all services.

DEPENDENT Dependents are typically children or spouses/partners of insured individuals. When individuals or employees buy health insurance, they usually have the choice to buy a plan that covers their spouse, partner or children. Some plans may allow other individuals in their care to be covered under the plan.

DISABILITY A limit in a range of major life activities. This includes limits on activities such as seeing, hearing, and walking and on tasks such as thinking and working. Because different health insurance programs may have different disability standards, please check the program you’re interested in for its disability standards.

EMERGENCY SERVICES Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

ESSENTIAL HEALTH BENEFITS A set of health care service categories that must be covered by Qualified Health Plans and certain plans starting in 2014. Essential health benefits must include items and services within at least the following 10 general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXCLUDED SERVICES Health care services that your health insurance or plan doesn't pay for or cover.

FEDERAL POVERTY LEVEL (FPL) A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits. The 2013 Federal Poverty Level for an individual is \$11,490 in yearly income and \$23,550 for a family of four.

FEE FOR SERVICE A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

FLEXIBLE BENEFITS PLAN A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans and childcare. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.

FLEXIBLE SPENDING ACCOUNT (FSA) An arrangement through an employer to pay for out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year.

There is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.

FORMULARY A list of drugs your insurance plan covers. A formulary may include how much you pay for each drug. If the plan uses "tiers," the formulary may list which drugs are in which tiers. Formularies may include both generic drugs and brand-name drugs.

GRANDFATHERED HEALTH PLAN As used in connection with the 2010 federal health law: A group health plan that was created—or an individual health insurance policy that was purchased on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the federal health law. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

GRIEVANCE A complaint that you communicate to your health insurer or plan.

GUARANTEED ISSUE A requirement that health plans must allow you to sign up for coverage, regardless of health status, age, gender, or other factors that might predict how much you use health services. Guaranteed issue doesn't limit how much you can be charged if you enroll.

GUARANTEED RENEWAL A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

HABILITATION SERVICES Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH INSURANCE A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

HEALTH SAVINGS ACCOUNT (HSA)

A medical savings account available to taxpayers who are enrolled in a qualified High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

HOSPICE SERVICES Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

HOSPITAL OUTPATIENT CARE Care in a hospital that usually doesn't require an overnight stay.

HOME HEALTH CARE Health care services a person receives at home.

IN-NETWORK CO-INSURANCE The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

IN-NETWORK CO-PAYMENT A fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.
Insurance Cooperatives (Co-ops)

A non-profit entity created to provide insurance and owned by those it insures. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners. Colorado's insurance cooperative is called the Colorado HealthOP.

LONG-TERM CARE Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term services can be provided at home, in the community, in assisted living facilities or in nursing homes. Individuals may need long-term care at any age. Medicare and most health insurance plans don't pay for long-term care.

MEDICAID A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program. Colorado's Medicaid program is operated by the Colorado Department of Healthcare Policy and Financing.

MEDICAL LOSS RATIO (MLR) A basic financial measurement of how much of the premium is used to pay for medical care versus overhead. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay for overhead expenses, such as administrative costs, salaries, marketing and agent commissions, and/or retaining some as profit. Federal law sets minimum medical loss ratios for different markets, as do some state laws.

MEDICARE A federal health insurance program for people age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

MINIMUM ESSENTIAL COVERAGE The type of coverage an individual needs to have to meet the individual responsibility requirement under federal law. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

NETWORK The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

OPEN ENROLLMENT PERIOD The period of time set up to allow you to choose from available plans, usually once a year.

OUT-OF-NETWORK CO-INSURANCE The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

OUT-OF-NETWORK CO-PAYMENT A fixed amount you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

OUT-OF-POCKET COSTS Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs typically include deductibles, coinsurance and copayments for covered services plus all costs for services that aren't covered.

OUT-OF-POCKET LIMIT (OOP) The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This does not include your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

PLAN YEAR/POLICY YEAR The 12-month period when a health plan provides coverage. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. This can sometimes be called a 'policy year.'

POINT-OF-SERVICE (POS) PLAN A type of plan in which you pay less if you use doctors, hospitals and other health care providers that belong to the plan's network. POS plans may require you to get a referral from your primary care doctor in order to see a specialist.

PREFERRED PROVIDER A medical provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you're allowed to see all preferred providers or if, instead, your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

PREFERRED PROVIDER ORGANIZATION (PPO) A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals and providers outside of the network for an additional cost.

PREMIUM The amount that must be paid for your health insurance. You and/or your employer usually pay it monthly, but it may sometimes be paid quarterly or yearly.

PREVENTIVE SERVICES Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease or other health problems.

PRIMARY CARE Health services that cover a range of prevention, wellness and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health related issues. They may also coordinate your care with specialists.

QUALIFIED HEALTH PLAN An insurance plan that is certified by Connect for Health Colorado, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

RATE REVIEW A process in which state insurance departments to review rate increases before insurance companies can apply them to you. In Colorado, this is conducted by the Colorado Division of Insurance in the Department of Regulatory Agencies.

REHABILITATION SERVICES Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

RESCISSION The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under federal law, rescission is illegal except in cases of fraud or intentional misrepresentation of facts as prohibited by the terms of the plan or coverage.

RIDER (EXCLUSIONARY RIDER) A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy.) In most states today, an exclusionary rider is an amendment, permitted in individual health insurance policies that permanently prohibits coverage for a health condition, body part or body system. Under federal law, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

SELF-INSURED PLAN A type of plan used primarily by larger companies where the employer collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Special Enrollment Period

A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. This can be allowed in the event of certain life events, such as marriage, the birth of a child, and loss of a job.

SUMMARY OF BENEFITS AND COVERAGE (SBC) An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the SBC when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

UCR (USUAL, CUSTOMARY AND REASONABLE) The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount for providers that are not contracted with the insurance company.

UNCOMPENSATED CARE Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

WAITING PERIOD (JOB-BASED COVERAGE) The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.

WELL-BABY AND WELL-CHILD VISITS Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

WELLNESS PROGRAMS A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.