PART 17
GRIEVANCE PROCEDURES

© 2015 by the State of New Mexico. All rights reserved.

13.10.17.1 ISSUING AGENCY:
Public Regulation Commission, Insurance Division.
[13.10.17.1 NMAC - Rp, 13.10.17.1 NMAC, 5-3-04]

13.10.17.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer, or administer health benefits plans including health benefits plans:

(1) with a point-of-service option that allows grievant to obtain health care services out of network;

(2) provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act (NMSA 1978 Sections 13-7-1 through 13-7-11);

(3) utilizing a preferred provider network, as defined under NMSA 1978 Section 59A-22A-3; and

(4) traditional fee-for-service indemnity plans.

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) only short-term travel, accident-only, student health, specified disease, or other limited benefits; or

(2) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit.

C. Conflicts. For purposes of this rule, if any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care or 13.10.16 NMAC, Provider Grievances, the provisions in this rule shall apply.

[13.10.17.2 NMAC - Rp, 13.10.17.2 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]
Prior versions: 02-01-2008

13.10.17.3 STATUTORY AUTHORITY:
NMSA 1978 Sections 59A-1-16, 59A-2-8, 59A-2-9, 59A-15-16, 59A-16-3, 59A-16-11, 59A-16-12, 59A-16-12.1, 59A-16-20, 59A-16-22, 59A-19-4, 59A-19-6, 59A-22A-7, 59A-46-10, 59A-46-11, 59A-57-2, 59A-57-4, and 59A-57-5.
[13.10.17.3 NMAC - Rp, 13.10.17.3 NMAC, 5-3-04; A, 2-1-08]

13.10.17.4 DURATION:
Permanent.
[13.10.17.4 NMAC - Rp, 13.10.17.4 NMAC, 5-3-04]

13.10.17.5 EFFECTIVE DATE:

© 2015 by the State of New Mexico. All rights reserved.

May 3, 2004, unless a later date is cited at the end of a section.
[13.10.17.5 NMAC - Rp, 13.10.17.5 NMAC, 5-3-04]

13.10.17.6 OBJECTIVE:
The purpose of this rule is to establish procedures for filing and processing adverse determination grievances and administrative grievances regarding actions taken or inaction by a health care insurer.
[13.10.17.6 NMAC - Rp, 13.10.17.6 NMAC, 5-3-04]

13.10.17.7 DEFINITIONS:
As used in this rule:

A. administrative grievance means an oral or written complaint submitted by or on behalf of a grievant regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

(1) administrative practices of the health care insurer that affects the availability, delivery, or quality of health care services;

(2) claims payment, handling or reimbursement for health care services; and

(3) terminations of coverage;

B. adverse determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate;

C. adverse determination grievance means an oral or written complaint submitted by or on behalf of a grievant regarding an adverse determination;

D. certification means a decision by a health care insurer that a health care service requested by a provider or grievant has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved;

E. culturally and linguistically appropriate manner of notice means:

(1) notice that meets the following requirements:

(a) the health care insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(b) the health care insurer must provide, upon request, a notice in any applicable non-English language;

(c) the health care insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care insurer; and

(2) for purposes of this definition, with respect to an address in any New Mexico county to

© 2015 by the State of New Mexico. All rights reserved.

which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually;

F. grievant means any of the following:

(1) a policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by the health care plan;

(2) an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan;

(3) medicaid recipients enrolled in a health care insurer's medicaid plan; or

(4) individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act;

G. health benefits plan means a health plan or a policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a traditional fee-for-service health benefits plan;

H. health care insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan;

I. health care professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

J. health care services means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay;

K. hearing officer, independent co-hearing officer or ICO means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings;

L. medical necessity or medically necessary means health care services determined by a provider, in consultation with the health care insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the health care insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease;

M. provider means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license;

N. rescission of coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

(1) the cancellation or discontinuance of coverage has only a prospective effect; or

(2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

© 2015 by the State of New Mexico. All rights reserved.

O. summary of benefits means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the grievant by the health care insurer or group contract holder;

P. termination of coverage means the cancellation or non-renewal of coverage provided by a health care insurer to a grievant but does not include a voluntary termination by a grievant or termination of a health benefits plan that does not contain a renewal provision;

Q. traditional fee-for-service indemnity benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage grievants to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services;

R. uniform standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the health care insurer consistent with the federal, national, and professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.

[13.10.17.7 NMAC - Rp, 13.10.17.7 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.8 COMPUTATION OF TIME:

Whenever this rule requires that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within three (3) working days of the date it was mailed.

[13.10.17.8 NMAC - Rp, 13.10.17.8 NMAC, 5-3-04]

13.10.17.9 GENERAL REQUIREMENTS REGARDING GRIEVANCE PROCEDURES:

A. Written grievance procedures required. Every health care insurer shall establish and maintain separate written procedures to provide for the presentation, review, and resolution of:

(1) adverse determination grievances; a health care insurer shall establish procedures for both standard and expedited review of adverse determination grievances that comply with the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC;

(2) administrative grievances; a health care insurer shall establish procedures for reviewing administrative grievances that comply with the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC; and

(3) if a grievance contains clearly divisible administrative and adverse decision issues, then the health care insurer shall initiate separate complaints for each issue; with an explanation of the insurer's actions contained in one acknowledgement letter.

B. Assistance to grievants. In those instances where a grievant makes an oral grievance or request for internal review to the health care insurer, or expresses interest in pursuing a written grievance, the health care insurer shall assist grievant to complete all the forms required to pursue internal review and shall advise grievant that the managed health care bureau of the insurance division is available for assistance.

C. Retaliatory action prohibited. No person shall be subject to retaliatory action by the health care insurer for any reason related to a grievance.

© 2015 by the State of New Mexico. All rights reserved.

[13.10.17.9 NMAC - Rp, 13.10.17.9 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]
Prior versions: 02-01-2008

13.10.17.10 INFORMATION ABOUT GRIEVANCE PROCEDURES:

A. For grievants. A health care insurer shall:

(1) include a clear and concise description of all grievance procedures, both internal and external, in boldface type in the enrollment materials, including in member handbooks or evidences of coverage, issued to grievants;

(2) for a person who has been denied coverage, provide him or her with a copy of the grievance procedures;

(3) notify grievants that a representative of the health care insurer and the managed health care bureau of the insurance division are available upon request to assist grievants with grievance procedures by including such information, and a toll-free telephone number for obtaining such assistance, in the enrollment materials and summary of benefits issued to grievants;

(4) provide a copy of its grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to a grievant, provider or other interested person;

(5) provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to a grievant or provider when the health care insurer makes either an adverse determination or adverse administrative decision; the written explanation shall describe how the health care insurer reviews and resolves grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of the health care insurer's consumer assistance office; and

(6) provide consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution;

(7) provide notice to enrollees in a culturally and linguistically appropriate manner as defined in Subsection E of 13.10.17.7 NMAC;

(8) provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal;

(9) not reduce or terminate an ongoing course of treatment without first notifying the grievant sufficiently in advance of the reduction or termination to allow the grievant to appeal and obtain a determination on review of the proposed reduction or termination; and

(10) allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.

B. For providers. A health care insurer shall inform all providers of the grievance procedures available to grievants and providers acting on behalf of grievants, and shall make all necessary forms available to providers, including consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution.

C. Special needs. Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101 et seq., and 13.10.13 NMAC, Managed Health Care, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.

[13.10.17.10 NMAC - Rp, 13.10.17.10 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]
Prior versions: 02-01-2008

13.10.17.11 CONFIDENTIALITY OF A COVERED PERSON'S RECORDS AND MEDICAL

© 2015 by the State of New Mexico. All rights reserved.

INFORMATION:

A. Confidentiality. Health care insurers, the superintendent, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of grievants when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

B. Procedures required. The superintendent and health care insurers shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of grievants submitted as part of any grievance.

[13.10.17.11 NMAC - Rp, 13.10.17.11 NMAC, 5-3-04; A, 5-15-12]

Prior versions: 05-03-2004

13.10.17.12 RECORD OF GRIEVANCES:

A. Record required. The health care insurer shall maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the superintendent.

B. Contents. For each grievance received, the grievance register shall:

(1) assign a grievance number;

(2) indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;

(3) state the date, and for an expedited review the time, the grievance was received;

(4) state the name and address of the grievant, if different from the grievant;

(5) identify by name and member number the grievant making the grievance or for whom the grievance was made;

(6) indicate whether the grievant's coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the medicaid program, or a commercial health care insurer;

(7) identify the health insurance policy number and the group if the policy is a group policy;

(8) identify the individual employee of the health care insurer to whom the grievance was made;

(9) describe the grievance;

(10) for adverse determination grievances, indicate whether the grievance received expedited or standard review;

(11) indicate at what level the grievance was resolved and what the actual outcome was; and

(12) state the date the grievance was resolved and the date the grievant was notified of the outcome.

C. Annual report. Each year, the superintendent shall issue a data call for information based on the grievances received and handled by a health care insurer during the prior calendar year. The data call will be based on the information contained in the grievance register.

D. Retention. The health care insurer shall maintain such records for at least six (6) years.

E. Submittal. The health care insurer shall submit information regarding all grievances involving quality of care issues to the health care insurer's continuous quality improvement committee and to the superintendent and shall document the qualifications and background of the continuous quality improvement committee members.

F. Examination. The health care insurer shall make such record available for examination

© 2015 by the State of New Mexico. All rights reserved.

upon request and provide such documents free of charge to a grievant, or state or federal agency officials, subject to any applicable federal or state law regarding disclosure of personally identifiable health information.

[13.10.17.12 NMAC - Rp, 13.10.17.12 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.13 PRELIMINARY DETERMINATION.

Upon receipt of a grievance, a health care insurer shall first determine the type of grievance at hand.

A. If the grievance seeks review of an adverse determination of a pre- or post- health care service, it is an adverse determination grievance and the health care insurer shall review the grievance in accordance with its procedures for adverse determination grievances and the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC.

B. If the grievance is not based on an adverse determination of a pre- or post- health care service, it is an administrative grievance and the health care insurer shall review the grievance in accordance with its procedures for administrative grievances and the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC.

[13.10.17.13 NMAC - N, 5-3-04; A, 2-1-08]

13.10.17.14 TIMEFRAMES FOR INITIAL DETERMINATIONS:

A. Expedited decision. A health care insurer shall make its initial certification or adverse determination decision in accordance with the medical exigencies of the case. The health care insurer shall make decisions within twenty-four (24) hours of the written or verbal receipt of the request for an expedited decision whenever:

(1) the life or health of a grievant would be jeopardized;

(2) the grievant's ability to regain maximum function would be jeopardized;

(3) the provider reasonably requests an expedited decision;

(4) in the opinion of the physician with knowledge of the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

(5) the medical exigencies of the case require an expedited decision; or

(6) the grievant's claim involves urgent care.

B. Standard decision. A health care insurer shall make all other initial utilization management decisions within five (5) working days. The health care insurer may extend the review period for a maximum of ten (10) working days if it:

(1) can demonstrate reasonable cause beyond its control for the delay;

(2) can demonstrate that the delay will not result in increased medical risk to the grievant; and

(3) provides a written progress report and explanation for the delay to the grievant and provider within the original five (5) working day review period.

[13.10.17.14 NMAC - Rp, 13.10.17.14 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.15 INITIAL DETERMINATION:

A. Coverage. When considering whether to certify a health care service requested by a

© 2015 by the State of New Mexico. All rights reserved.

provider or grievant, the health care insurer shall determine whether the requested health care service is covered by the health benefits plan. Before denying a health care service requested by a provider or grievant on grounds of a lack of coverage, the health care insurer shall determine that there is no provision of the health benefits plan under which the requested health care service could be covered. If the health care insurer finds that the requested health care service is not covered by the health benefits plan, the health care insurer need not address the issue of medical necessity.

B. Medical necessity.

(1) If the health care insurer finds that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a provider or grievant, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested health care service is medically necessary.

(2) Before a health care insurer denies a health care service requested by a provider or grievant on grounds of a lack of medical necessity, a physician shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer. The physician shall be under the clinical authority of the medical director responsible for health care services provided to grievants.

[13.10.17.15 NMAC - Rp, 13.10.17.13 NMAC & 13.10.17.16 NMAC, 5-3-04; A, 5-15-12]

Prior versions: 05-03-2004

13.10.17.16 NOTICE OF INITIAL DETERMINATION:

A. Certification. The health care insurer shall notify the grievant and provider of the certification by written or electronic communication within two (2) working days of the date the health care service was certified, unless earlier notice is required by the medical exigencies of the case.

B. 24-hour notice of adverse determination; explanatory contents. The health care insurer shall notify a grievant and provider of an adverse determination by telephone or as required by the medical exigencies of the case, but in no case later than twenty-four (24) hours after making the adverse determination, unless the grievant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage. If the grievant fails to provide such information, he or she must be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Additionally, the health care insurer shall notify the covered person and provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice.

C. Contents of notice of adverse determination.

(1) if the adverse determination is based on a lack of medical necessity, clearly and completely explain why the requested health care service is not medically necessary; a statement that the health care service is not medically necessary will not be sufficient;

(2) if the adverse determination is based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(3) the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

© 2015 by the State of New Mexico. All rights reserved.

(4) nclude a description of the health care insurer standard that was used in denying the claim;

(5) provide a summary of the discussion which triggered the final determination;

(6) advise the grievant that he or she may request internal or external review of the health care insurer's adverse determination; and

(7) describe the procedures and provide all necessary forms to the grievant for requesting internal appeals and external reviews.

[13.10.17.16 NMAC - Rp, 13.10.17.17 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12; A, 5-31-12]

Prior versions: 02-01-2008, 05-15-2012

13.10.17.17 RIGHTS REGARDING INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Right to internal review. Every grievant who is dissatisfied with an adverse determination shall have the right to request internal review of the adverse determination by the health care insurer.

B. Acknowledgement of request. Upon receipt of a request for internal review of an adverse determination, the health care insurer shall date and time stamp the request and, within one (1) working day from receipt, send the grievant an acknowledgment that the request has been received. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the grievance.

C. Full and fair hearing. To ensure that a grievant receives a full and fair internal review, the healthcare insurer must, in addition to allowing the grievant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process, provide the grievant, free of charge, with any new or additional evidence, and new or additional rationale, considered, relied upon, or generated by the health care insurer, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit determination to allow the grievant a reasonable opportunity to respond before the final internal adverse benefit determination is made.

D. Conflict of interest. The health care insurer must ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

[13.10.17.17 NMAC - Rp, 13.10.17.18 NMAC, 5-3-04; A, 5-15-12]

Prior versions: 05-03-2004

13.10.17.18 TIMEFRAMES FOR INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

Upon receipt of a request for internal review of an adverse determination, the health care insurer shall conduct either a standard or expedited review, as appropriate.

A. Expedited review. A health care insurer shall complete its internal review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours from the time the internal review request was received whenever:

(1) the life or health of a grievant would be jeopardized;

(2) the grievant's ability to regain maximum function would be jeopardized;

(3) the provider reasonably requests an expedited decision;

(4) in the opinion of the physician with knowledge of the grievant's medical condition,

© 2015 by the State of New Mexico. All rights reserved.

would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

(5) the medical exigencies of the case require an expedited decision.

B. Standard review. A health care insurer shall complete a standard review of both internal reviews as described in 13.10.17.19 NMAC and 13.10.17.20 NMAC within twenty (20) working days of receipt of the request for internal review in all cases in which the request for review is made prior to the service requested, and does not require expedited review, and within forty (40) working days of receipt of the request in all post-service requests for internal review. The health care insurer may extend the review period for a maximum of ten (10) working days in pre-service cases, and twenty (20) working days for post-service cases if it:

(1) can demonstrate reasonable cause beyond its control for the delay;

(2) can demonstrate that the delay will not result in increased medical risk to the grievant; and

(3) provides a written progress report and explanation for the delay to the grievant and provider within the original thirty (30) day for pre-service or sixty (60) day for post-service review period;

(4) if the grievance contains clearly divisible administrative and adverse decision issues, then the health care insurer shall initiate separate complaints for each decision.

C. Failure to comply with deadline. If the health care insurer fails to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless the grievant, after being fully informed of his or her rights, has agreed in writing to extend the deadline.

[13.10.17.18 NMAC - Rp, 13.10.17.19 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.19 FIRST AND SECOND INTERNAL REVIEW OF ADVERSE DETERMINATIONS FOR GROUP HEALTH PLANS:

A. Applicability. This section applies only to health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act that conduct the first level of the internal appeal, and health care insurers who offer group health care benefits plans that conduct the second level of the internal appeal.

B. Scope of review. Health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act shall complete the review of the adverse determination within the timeframes established in 13.10.17.18 NMAC.

(1) Coverage. If the initial adverse determination was based on a lack of coverage, the health care insurer shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

(2) Medical necessity. If the initial adverse determination was based on a lack of medical necessity, the health care insurer shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

C. Decision to reverse. If the health care insurer reverses the initial adverse determination and certifies the requested health care service, the health care insurer shall notify the grievant and provider as required by 13.10.17.16 NMAC.

D. Decision to uphold. If the health care insurer upholds the initial adverse determination to deny the requested health care service, the health care insurer shall notify the grievant and provider as

© 2015 by the State of New Mexico. All rights reserved.

required by 13.10.17.16 NMAC and shall ascertain whether the grievant wishes to pursue the grievance.

(1) If the grievant does not wish to pursue the grievance, the health care insurer shall mail written notification of health care insurer's decision, and confirmation of the grievant's decision not to pursue the matter further, to the grievant within three (3) working days of the health care insurer's decision.

(2) If the health care insurer is unable to contact the grievant by telephone within seventy-two (72) hours of making the decision to uphold the determination, the health care insurer shall notify the grievant by mail of the health care insurer's decision and shall include in the notification a self-addressed stamped response form which asks the grievant whether he or she wishes to pursue the grievance further and provides a box for checking "yes" and a box for checking "no." If the grievant does not return the response form within ten (10) working days, the health care insurer shall again contact the grievant by telephone.

(3) If the grievant responds affirmatively to the telephone inquiry or by response form, the health care insurer will select a medical panel to further review the adverse determination as described in 13.10.17.20 NMAC.

(4) If the grievant does not respond to the health care insurer's telephone inquiries or return the response form, the health care insurer shall select a medical panel to further review the adverse determination when the review is an expedited review.

E. Extending the timeframe for standard review. If the grievant does not make an immediate decision to pursue the grievance, or the grievant has requested additional time to supply supporting documents or information, or postponement pursuant to Subsection G of 13.10.17.20 NMAC, the timeframe described in Subsection B of 13.10.17.18 NMAC shall be extended to include the additional time required by the grievant.

[13.10.17.19 NMAC - Rp, 13.10.17.20 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.20 INTERNAL PANEL REVIEW OF ADVERSE DETERMINATIONS:

A. Selection of an internal review panel. In cases of appeal from an adverse determination or from a third party administrator's decision to uphold an adverse determination, the issuer shall select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.

B. Notice of review. Unless the grievant chooses not to pursue the grievance, the health care insurer shall notify the grievant of the date, time, and place of the internal panel review. The notice shall advise the grievant of the rights specified in Subsection G of this section. If the health care insurer indicates that it will have an attorney represent its interests, the notice shall advise the grievant that an attorney will represent the health care insurer and that the grievant may wish to obtain legal representation of their own.

C. Panel membership. The health care insurer shall select one or more representatives of the health care insurer and one or more health care or other professionals who have not been previously involved in the adverse determination being reviewed to serve on the internal review panel. At least one of the health care professionals selected shall practice in a specialty that would typically manage the case that is the subject of the grievance or be mutually agreed upon by the grievant and the health care insurer.

D. Scope of review.

(1) Coverage. The internal review panel shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

© 2015 by the State of New Mexico. All rights reserved.

(2) Medical necessity. The internal review panel shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

E. Information to grievant. No fewer than three (3) working days prior to the internal panel review, the health care insurer shall provide to the grievant copies of:

(1) the grievant's pertinent medical records;

(2) the treating provider's recommendation;

(3) the grievant's health benefits plan;

(4) the health care insurer's notice of adverse determination;

(5) uniform standards relevant to the grievant's medical condition that is used by the internal panel in reviewing the adverse determination;

(6) questions sent to or reports received from any medical consultants retained by the health care insurer; and

(7) all other evidence or documentation relevant to reviewing the adverse determination.

F. Request for postponement. The health care insurer shall not unreasonably deny a request for postponement of the internal panel review made by the grievant. The timeframes for internal panel review shall be extended during the period of any postponement.

G. Rights of grievant. A grievant has the right to:

(1) attend and participate in the internal panel review;

(2) present his or her case to the internal panel;

(3) submit supporting material both before and at the internal panel review;

(4) ask questions of any representative of the health care insurer;

(5) ask questions of any health care professionals on the internal panel;

(6) be assisted or represented by a person of her choice, including legal representation; and

(7) hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

H. Timeframe for review; attendance. The internal review panel will complete its review of the adverse determination as required by the medical exigencies of the case and within the timeframes set forth in 13.10.17.18 NMAC. Internal review panel members must be present physically or by video or telephone conferencing to hear the grievance. An internal review panel member who is not present to hear the grievance either physically or by video or telephone conferencing shall not participate in the decision.

[13.10.17.20 NMAC - Rp, 13.10.17.21 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.21 ADDITIONAL REQUIREMENTS FOR EXPEDITED INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. In an expedited review, all information required by Subsection D of 13.10.17.20 NMAC shall be transmitted between the health care insurer and the grievant by the most expeditious method available.

B. If an expedited review is conducted during a patient's hospital stay or course of treatment, health care services shall be continued without cost (except for applicable co-payments and deductibles) to the grievant until the health care insurer makes a final decision and notifies the grievant.

C. A health care insurer shall not conduct an expedited review of an adverse determination made after health care services have been provided to a grievant.

[13.10.17.21 NMAC - Rp, 13.10.17.22 NMAC, 5-3-04; A, 5-15-12]

© 2015 by the State of New Mexico. All rights reserved.

Prior versions: 05-03-2004

13.10.17.22 NOTICE OF INTERNAL PANEL DECISION:

A. Notice required. Within the time period allotted for completion of its internal review, the health care insurer shall notify the grievant and provider of the internal review panel's decision by telephone within twenty-four (24) hours of the panel's decision and in writing or by electronic means within one (1) working day of the telephone notice.

B. Contents of notice. The written notice shall contain:

(1) the names, titles, and qualifying credentials of the persons on the internal review panel;

(2) a statement of the internal panel's understanding of the nature of the grievance and all pertinent facts;

(3) a description of the evidence relied on by the internal review panel in reaching its decision;

(4) a clear and complete explanation of the rationale for the internal review panel's decision;

(a) the notice shall identify every provision of the grievant's health benefits plan relevant to the issue of coverage in the case under review, and explain why each provision did or did not support the panel's decision regarding coverage of the requested health care service;

(b) the notice shall cite the uniform standards relevant to the grievant's medical condition and explain whether each supported or did not support the panel's decision regarding the medical necessity of the requested health care service;

(5) notice of the grievant's right to request external review by the superintendent, including the address and telephone number of the managed health care bureau of the insurance division, a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate external review; this notice of the grievant's right to request external review is in addition to the same notice provided the grievant in the summary of benefits and health benefits plan.

[13.10.17.22 NMAC - Rp, 13.10.17.23 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.23 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Right to external review. Every grievant who is dissatisfied with the results of a medical panel review of an adverse determination by a health care insurer and where applicable, with the results of a grievance review by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, may request external review by the superintendent at no cost to the grievant. There shall be no minimum dollar amount of a claim before a grievant may exercise this right to external review.

B. Exhaustion of internal appeals process. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

C. Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

(1) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

(3) the grievant simultaneously requests an expedited internal appeal and an expedited

© 2015 by the State of New Mexico. All rights reserved.

external review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are de minimus and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the health care insurer shall provide the grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

[13.10.17.23 NMAC - Rp, 13.10.17.24 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.24 FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Deadline for filing request.

(1) When required by the medical exigencies of the case. If required by the medical exigencies of the case, a grievant or provider may telephonically request an expedited review by calling the managed health care bureau at (505) 827-3928 or 1-877-673-1732.

(2) In all other cases. To initiate an external review, a grievant must file a written request for external review with the superintendent within one hundred twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the superintendent for good cause shown. The cost of the external review will be borne by the health care insurer or health care plan. The request shall be:

(a) mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269; or

(b) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;

(c) faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, at (505) 827-4734; or

(d) completed on-line with a NMPRC, Division of Insurance Complaint Form available at http://www.nmprc.state.nm.us.

B. Documents required to be filed by the grievant. The grievant shall file the request for external review on the forms provided to the grievant by the health care insurer or entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act pursuant to Paragraph (5) of Subsection B of 13.10.17.22 NMAC, and shall also file:

© 2015 by the State of New Mexico. All rights reserved.

(1) a copy of the notice of internal review decision;

(2) a fully executed release form authorizing the superintendent to obtain any necessary medical records from the health care insurer or any other relevant provider; and

(3) if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation as described in Subsection B of 13.10.17.28 NMAC.

C. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

D. Extending timeframes for external review. If a grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

[13.10.17.24 NMAC - Rp, 13.10.17.25 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.25 ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF ADVERSE DETERMINATION AND COPY TO HEALTH CARE INSURER:

A. Upon receipt of a request for external review, the superintendent shall immediately send:

(1) the grievant an acknowledgment that the request has been received;

(2) the health care insurer a copy of the request for external review.

B. Upon receipt of the copy of the request for external review, the health care insurer shall, within five (5) working days for standard review or the time limit set by the superintendent for expedited review, provide to the superintendent and the grievant by any available expeditious method:

(1) the summary of benefits;

(2) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;

(3) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;

(4) uniform standards relevant to the grievant’s medical condition that were used by the internal panel in reviewing the adverse determination; and

(5) any other documents, records, and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

C. If the health care insurer fails to comply with the requirements of Subsection B of this section, the superintendent may reverse the adverse determination.

D. The superintendent may waive the requirements of this section if necessitated by the medical exigencies of the case.

[13.10.17.25 NMAC - Rp, 13.10.17.26 NMAC, 5-3-04; A, 2-1-08]

13.10.17.26 TIMEFRAMES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS: The superintendent shall conduct either a standard or expedited external review of the adverse determination, as required by the medical exigencies of the case.

A. Expedited review.

(1) The superintendent shall complete an external review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours of receipt of the external review request whenever:

© 2015 by the State of New Mexico. All rights reserved.

(a) the life or health of a grievant would be jeopardized; or

(b) the grievant's ability to regain maximum function would be jeopardized.

(2) If the superintendent's initial decision is made orally, written notice of the decision must be provided within forty-eight (48) hours of the oral notification.

B. Standard review. The superintendent shall conduct a standard review in all cases not requiring expedited review. Insurance division staff shall complete the initial review within ten (10) working days from receipt of the request for external review and the information required of the grievant and health care insurer in Subsection B of 13.10.17.24 and Subsection B of 13.10.17.25 NMAC respectively. If a hearing is held in accordance with 13.10.17.30 NMAC, the superintendent shall complete the external review within forty-five (45) working days from receipt of the complete request for external review in compliance with 13.10.17.24 NMAC. The superintendent may extend the external review period for up to an additional ten (10) working days when the superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to the grievant.

[13.10.17.26 NMAC - Rp, 13.10.17.27 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.27 CRITERIA FOR INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY INSURANCE DIVISION STAFF:

Upon receipt of the request for external review, insurance division staff shall review the request to determine whether:

A. the grievant has provided the documents required by Subsection B of 13.10.17.24 NMAC;

B. the individual is or was a grievant of the health care insurer at the time the health care service was requested or provided;

C. the grievant has exhausted the health care insurer's internal review procedure and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act; and

D. the health care service that is the subject of the grievance reasonably appears to be a covered benefit under the health benefits plan.

[13.10.17.27 NMAC - Rp, 13.10.17.28 NMAC, 5-3-04; A, 5-15-12]

Prior versions: 05-03-2004

13.10.17.28 ADDITIONAL CRITERIA FOR INITIAL EXTERNAL REVIEW OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT ADVERSE DETERMINATIONS BY INSURANCE DIVISION STAFF:

If the request is for external review of an experimental or investigational treatment adverse determination, insurance division staff shall also consider whether:

A. coverage; the recommended or requested health care service:

(1) reasonably appears to be a covered benefit under the grievant's health benefit plan except for the health care insurer's determination that the health care service is experimental or investigational for a particular medical condition; and

(2) is not explicitly listed as an excluded benefit under the grievant's health benefit plan; and

B. medical necessity; the grievant's treating provider has certified that:

© 2015 by the State of New Mexico. All rights reserved.

(1) standard health care services have not been effective in improving the grievant's condition; or

(2) standard health care services are not medically appropriate for the grievant; or

(3) there is no standard health care service covered by the health care insurer that is as beneficial or more beneficial than the health care service:

(a) recommended by the grievant's treating provider that the treating provider certifies in writing is likely to be more beneficial to the grievant, in the treating provider's opinion, than standard health care services; or

(b) requested by the grievant regarding which the grievant's treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the grievant's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by the grievant is likely to be more beneficial to the grievant than available standard health care services.

[13.10.17.28 NMAC - Rp, 13.10.17.29 NMAC, 5-3-04; A, 5-15-12]

Prior versions: 05-03-2004

13.10.17.29 INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY INSURANCE DIVISION STAFF:

A. Request incomplete. If the request for external review is incomplete, insurance division staff shall immediately notify the grievant and require the grievant to submit the information required by Subsection B of 13.10.17.25 NMAC within a specified period of time.

B. Request does not meet criteria. If the request for external review does not meet the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request does not meet the criteria for external review and is thereby denied, and that the grievant has the right to request a hearing in the manner provided by NMSA 1978 Sections 59A-4-15 and 59A-4-18 within thirty-three (33) days from the date the notice was mailed.

C. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to NMSA 1978 Section 59A-4-18 and 13.10.17.30 NMAC has been set to determine whether, as a result of the health care insurer's adverse determination, the grievant was deprived of medically necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with NMSA 1978 Section 12-8-10.

D. Notice of hearing. The notice of hearing shall be mailed no later than eight (8) working days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise the grievant and the health care insurer of the rights specified in Subsection G of 13.10.17.30 NMAC. The superintendent shall not unreasonably deny a request for postponement of the hearing made by the grievant or the health care insurer.

[13.10.17.29 NMAC - Rp, 13.10.17.30 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.30 HEARING PROCEDURES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Conduct of hearing. The superintendent may designate a hearing officer who shall be

© 2015 by the State of New Mexico. All rights reserved.

an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense.

B. Co-hearing officers. The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. If the superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

C. Powers. The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:

(1) require the production of additional records, documents, and writings relevant to the subject of the grievance;

(2) exclude any irrelevant, immaterial, or unduly repetitious evidence; and

(3) if the grievant or health care insurer fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

D. Staff participation. Staff may attend the hearing, ask questions, and otherwise solicit evidence from the parties, but shall not be present during deliberations among the superintendent or his designated hearing officer and any independent co-hearing officers.

E. Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine the grievant, the health care insurer, and other witnesses.

F. Hearing recorded. The hearing shall be stenographically recorded at the insurance division's expense.

G. Rights of parties. Both the grievant and the health care insurer have the right to:

(1) attend the hearing; the health care insurer shall designate a person to attend on its behalf and the grievant may designate a person to attend on grievant's behalf if the grievant chooses not to attend personally;

(2) be assisted or represented by an attorney or other person;

(3) call, examine and cross-examine witnesses; and

(4) submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing and require that the information be submitted to the health care insurer and the MHCB staff.

H. Stipulation. The grievant and the health care insurer shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review.

[13.10.17.30 NMAC - Rp, 13.10.17.31 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.31 INDEPENDENT CO-HEARING OFFICERS (ICOs):

A. Identification of ICOs. The superintendent shall provide for maintenance of a list of licensed professionals qualified to serve as independent co-hearing officers. The superintendent shall select appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co-hearing officers in external reviews who maintain independence and impartiality of the process.

B. Disclosure of interests. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all health care insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly

© 2015 by the State of New Mexico. All rights reserved.

describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the grievant or to the health care insurer or providers involved in a particular external review.

C. Compensation of hearing officers and ICOs.

(1) Compensation schedule. The superintendent shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for health care and other professionals who are appointed as ICOs for external grievance reviews and shall annually publish a schedule of ICO compensation in a bulletin.

(2) Statement of ICO compensation. Upon completion of an external review, the attorney and co-hearing officers shall each complete a statement of ICO compensation form prescribed by the superintendent detailing the amount of time spent participating in the external review and submit it to the superintendent for approval. The superintendent shall send the approved statement of ICO compensation to the grievant's health care insurer.

(3) Direct payment to ICOs. Within thirty (30) days of receipt of the statement of ICO compensation, the grievant's health care insurer shall remit the approved compensation directly to the ICO.

(4) No compensation with early settlement. If the parties provide written notice of a settlement up to three (3) working days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOs.

D. The hearing officer and ICOs must maintain written records for a period of three (3) years and make them available upon request to the state.

[13.10.17.31 NMAC - Rp, 13.10.17.32 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.32 SUPERINTENDENT'S DECISION ON EXTERNAL REVIEW OF ADVERSE DETERMINATION:

A. Deliberation. At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law, and a recommended decision. Any hearing officer may submit a supplementary or dissenting opinion to the recommended decision.

B. Order. Within the time period allotted for external review, the superintendent shall issue an appropriate order. If the order requires action on the part of the health care insurer, the order shall specify the timeframe for compliance.

(1) The order shall be binding on the grievant and the health care insurer and shall state that the grievant and the health care insurer have the right to judicial review pursuant to NMSA 1978 Section 59A-4-20 and that state and federal law may provide other remedies.

(2) Neither the grievant nor the health care insurer may file a subsequent request for external review of the same adverse determination that was the subject of the superintendent's order.

[13.10.17.32 NMAC - Rp, 13.10.17.33 NMAC, 5-3-04; A, 2-1-08]

13.10.17.33 INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES:

A. Request for internal review of grievance. Any person dissatisfied with a decision, action or inaction of a health care insurer, including termination of coverage, has the right to request internal review of an administrative grievance orally or in writing.

B. Acknowledgement of grievance. Within three (3) working days after receipt of an administrative grievance, the health care insurer shall send the grievant a written acknowledgment that it

© 2015 by the State of New Mexico. All rights reserved.

has received the administrative grievance. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the administrative grievance.

C. Initial review. The health care insurer shall promptly review the administrative grievance. The initial review shall:

(1) be conducted by a health care insurer representative authorized to take corrective action on the administrative grievance; and

(2) allow the grievant to present any information pertinent to the administrative grievance.

[13.10.17.33 NMAC - Rp, 13.10.17.34 NMAC, 5-3-04]

13.10.17.34 INITIAL INTERNAL REVIEW DECISION ON ADMINISTRATIVE GRIEVANCE: The health care insurer shall mail a written decision to the grievant within fifteen (15) working days of receipt of the administrative grievance. The fifteen (15) working day period may be extended when there is a delay in obtaining documents or records necessary for the review of the administrative grievance, provided that the health care insurer notifies the grievant in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the health care insurer and the grievant. The written decision shall contain:

A. the name, title, and qualifications of the person conducting the initial review;

B. a statement of the reviewer's understanding of the nature of the administrative grievance and all pertinent facts;

C. a clear and complete explanation of the rationale for the reviewer's decision;

D. identification of the health benefits plan provisions relied upon in reaching the decision;

E. reference to evidence or documentation considered by the reviewer in making the decision;

F. a statement that the initial decision will be binding unless the grievant submits a request for reconsideration within twenty (20) working days of receipt of the initial decision; and

G. a description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.

[13.10.17.34 NMAC - Rp, 13.10.17.35 NMAC, 5-3-04; A, 2-1-08]

13.10.17.35 RECONSIDERATION OF INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Committee. Upon receipt of a request for reconsideration, the health care insurer shall appoint a reconsideration committee consisting of one or more employees of the health care insurer who have not participated in the initial decision. The health care insurer may include one or more employees other than the grievant to participate on the reconsideration committee.

B. Hearing. The reconsideration committee shall schedule and hold a hearing within fifteen (15) working days after receipt of a request for reconsideration. The hearing shall be held during regular business hours at a location reasonably accessible to the grievant, and the health care insurer shall offer the grievant the opportunity to communicate with the committee, at the health care insurer's expense, by conference call, video conferencing, or other appropriate technology. The health care insurer shall not unreasonably deny a request for postponement of the hearing made by a grievant.

C. Notice. The health care insurer shall notify the grievant in writing of the hearing date, time and place at least ten (10) working days in advance. The notice shall advise the grievant of the rights specified in Subsection E of this section. If the health care insurer will have an attorney represent its

© 2015 by the State of New Mexico. All rights reserved.

interests, the notice shall advise the grievant that the health care insurer will be represented by an attorney and that the grievant may wish to obtain legal representation of her own.

D. Information to grievant. No fewer than three (3) working days prior to the hearing, the health care insurer shall provide to the grievant all documents and information that the committee will rely on in reviewing the case.

E. Rights of grievant. A grievant has the right to:

(1) attend the reconsideration committee hearing;

(2) present their case to the reconsideration committee;

(3) submit supporting material both before and at the reconsideration committee hearing;

(4) ask questions of any representative of the health care insurer; and

(5) be assisted or represented by a person of their choice.

[13.10.17.35 NMAC - Rp, 13.10.17.36 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

Prior versions: 02-01-2008

13.10.17.36 DECISION OF RECONSIDERATION COMMITTEE:

The health care insurer shall mail a written decision to the grievant within seven (7) working days after the reconsideration committee hearing. The written decision shall include:

A. the names, titles, and qualifications of the persons on the reconsideration committee;

B. the reconsideration committee's statement of the issues involved in the administrative grievance;

C. a clear and complete explanation of the rationale for the reconsideration committee's decision;

D. the health benefits plan provision relied on in reaching the decision;

E. references to the evidence or documentation relied on in reaching the decision;

F. a statement that the initial decision will be binding unless the grievant submits a request for external review by the superintendent within twenty (20) working days of receipt of the reconsideration decision; and

G. a description of the procedures and deadlines for requesting external review by the superintendent, including any necessary forms. The notice shall contain the toll-free telephone number and address of the superintendent's office.

[13.10.17.36 NMAC - Rp, 13.10.17.37 NMAC, 5-3-04]

13.10.17.37 EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES:

A. Right to external review. Every grievant who is dissatisfied with the results of the internal review of an administrative decision shall have the right to request external review by the superintendent.

B. Exhaustion of remedies. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

C. Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

(1) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

© 2015 by the State of New Mexico. All rights reserved.

(3) the grievant simultaneously requests an expedited internal appeal and an expedited internal appeal and an expedited external review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are de minimus and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the health care insurer shall provide the grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon grievant receipt of such notice.

[13.10.17.37 NMAC - Rp, 13.10.17.38 NMAC, 5-3-04; A, 5-15-12]

Prior versions: 05-03-2004

13.10.17.38 FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Deadline for filing request. To initiate an external review, a grievant must file a written request for external review with the superintendent within twenty (20) working days from receipt of the written notice of reconsideration decision. The request shall either be:

(1) mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation Commission, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;

(2) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;

(3) faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, (505) 827-4734; or

(4) completed on-line using a NM PRC, Division of Insurance Complaint Form available at http://www.nmprc.state.nm.us.

B. Documents required to be filed by the grievant. The grievant shall file the request for external review on the forms provided to the grievant by the health care insurer pursuant to Subsection G of 13.10.17.36 NMAC.

C. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

D. Extending timeframes for external review. If a grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

© 2015 by the State of New Mexico. All rights reserved.

[13.10.17.38 NMAC - Rp, 13.10.17.39 NMAC, 5-3-04; A, 2-1-08]

13.10.17.39 ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE AND COPY TO HEALTH CARE INSURER:

A. Upon receipt of a request for external review, the superintendent shall immediately send the:

(1) grievant an acknowledgment that the request has been received;

(2) health care insurer a copy of the request for external review.

B. Upon receipt of the copy of the request for external review, the health care insurer shall provide to the superintendent and the grievant by any available expeditious method within five (5) working days all necessary documents and information considered in arriving at the administrative grievance decision.

[13.10.17.39 NMAC - Rp, 13.10.17.40 NMAC, 5-3-04; A, 2-1-08]

13.10.17.40 REVIEW OF ADMINISTRATIVE GRIEVANCE BY SUPERINTENDENT:

The superintendent shall review the documents submitted by the health care insurer and the grievant, and may conduct an investigation or inquiry or consult with the grievant, as appropriate. The superintendent shall issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review in compliance with 13.10.17.38 NMAC.

[13.10.17.40 NMAC - Rp, 13.10.17.41 NMAC, 5-3-04; A, 2-1-08]

HISTORY OF 13.10.17 NMAC:

NMAC history:

13.10.17 NMAC, Grievance Procedures, effective 7-1-00.
13.10.17 NMAC, Grievance Procedures, effective 3-31-04
13.10.17 NMAC, Grievance Procedures, effective 2-1-08.

History of repealed material:

13 NMAC 10.17, Grievance Procedure for Enrollees Covered by Risk Management Division (filed 11-02-98), repealed, 7-1-00
13.10.17 NMAC, Grievance Procedures (filed 06-14-00), repealed 3-31-04.

© 2015 by the State of New Mexico. All rights reserved.