

**TITLE 13                   INSURANCE**  
**CHAPTER 10               HEALTH INSURANCE**  
**PART 17                   GRIEVANCE PROCEDURES**

**13.10.17.1   ISSUING AGENCY:** Office of Superintendent of Insurance (OSI), Managed Health Care Bureau (MHCB).

[13.10.17.1 NMAC - Rp, 13.10.17.1 NMAC, 1/1/16]

**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 (Sections 13-7-1 through 13-7-11 NMSA 1978);

**(3)**   utilizing a preferred provider network, as defined under Section 59A-22A-3 NMSA 1978; 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, 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 purpose 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, 1/1/16]

**13.10.17.3   STATUTORY AUTHORITY:** 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 NMSA 1978.

[13.10.17.3 NMAC - Rp, 13.10.17.3 NMAC, 1/1/16]

**13.10.17.4   DURATION:** Permanent.

[13.10.17.4 NMAC - Rp, 13.10.17.4 NMAC, 1/1/16]

**13.10.17.5   EFFECTIVE DATE:** January 1, 2016, unless a later date is cited at the end of a section.

[13.10.17.5 NMAC - Rp, 13.10.17.5 NMAC, 1/1/16]

**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, 1/1/16]

**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 a 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; and
  - (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.

(2) For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent 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 human services (HHS); the counties that meet this 10 percent 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 the 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, non-profit 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 (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. "Independent review"** means a process that is conducted at the discretion of the grievant by an independent review organization designated by the superintendent.

**M. "Independent review organization (IRO)"** means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations; and which renders an independent and impartial decision on a final adverse benefit determination.

**N. "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.

**O. "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.

**P. “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.

**Q. “Summary of benefits”** means the written materials required by Section 59A-57-4 NMSA 1978 to be given to the grievant by the health care insurer or group contract holder.

**R. “Superintendent”** means the superintendent of insurance.

**S. “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.

**T. “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.

**U. “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, 1/1/16]

**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 working days of the date it was mailed.

[13.10.17.8 NMAC - Rp, 13.10.17.8 NMAC, 1/1/16]

### **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 result 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 13.10.17.34 NMAC through 13.10.17.37 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 health care insurer's actions contained in one acknowledgment 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 MHCB of the OSI 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.

[13.10.17.9 NMAC - Rp, 13.10.17.9 NMAC, 1/1/16]

### **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 a 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 MHCB of OSI 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;

(6) provide consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the health care 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 on-going course of treatment pending the outcome of an internal appeal;

(9) not reduce or terminate an on-going 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 on-going 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 health care 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.*, The Patient Protection and Affordable Care Act of 2010, P.L. 111-152 as codified in the U.S.C. 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, 1/1/16]

### **13.10.17.11 CONFIDENTIALITY OF A GRIEVANT'S RECORDS AND MEDICAL INFORMATION:**

**A. Confidentiality.** Health care insurers, the superintendent, ICOs 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, 1/1/16]

### **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 was an expedited or a 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 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 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, 1/1/16]

**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 13.10.17.29 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 13.10.17.34 NMAC through 13.10.17.41 NMAC.

[13.10.17.13 NMAC - Rp, 13.10.17.13 NMAC, 1/1/16]

**13.10.17.14 TIME FRAMES 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 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 working days. The health care insurer may extend the review period for a maximum of 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 working day review period.

[13.10.17.14 NMAC - Rp, 13.10.17.14 NMAC, 1/1/16]

#### **13.10.17.15 INITIAL DETERMINATION:**

**A. Coverage.** When considering whether to certify a health care service requested by a 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 time frame 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, 13.10.17.15 NMAC, 1/1/16]

#### **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 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 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 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 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.

(4) Include 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.

(7) Describe the procedures and provide all necessary forms to the grievant for requesting internal appeals and external review by an IRO.

[13.10.17.16 NMAC - Rp, 13.10.17.16 NMAC, 1/1/16]

**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 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 internal review.** To ensure that a grievant receives a full and fair internal review, the health care 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, 13.10.17.17 NMAC, 1/1/16]

### **13.10.17.18 TIME FRAMES 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 an expedited internal review as required by the medical exigencies of the case, but in no case later than 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, 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 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 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 10 working days in pre-service cases, and 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;
- (3) provides a written progress report and explanation for the delay to the grievant and provider within the original 30 day for pre-service or 60 day for post-service review period; and
- (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 and the requirements of this subsection, 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, 13.10.17.18 NMAC, 1/1/16]

### **13.10.17.19 FIRST AND SECOND INTERNAL REVIEW OR ADVERSE**

#### **DETERMINATIONS FOR GROUP HEALTH PLANS:**

**A. Applicability.** This section applies only to health care insurers offering group health care benefits plans and entities subject to the Health Care Purchasing Act (public employees and retirees, public school employees and retirees only) that conduct the second level

of the internal appeal, and health care insurers who offer group health care benefits plans that conduct the first level of the internal appeal.

**B. Scope of review.** Health care insurers offering group health care benefits plans and entities subject to the Health Care Purchasing Act shall complete the review of the adverse determination within the time frames 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 specialist 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 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 working days of the health care insurer's decision.

(2) If the health care insurer is unable to contact the grievant by telephone within 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 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 time frame 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 time frame 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, 1/1/16]

### **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 health care insurer 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 13.10.17.20 NMAC. 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.

(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 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 time frames 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 his or 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. Time frame 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 time frames 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, 1/1/16]

#### **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, 1/1/16]

#### **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 24 hours of the panel's decision and in writing or by electronic means with one 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; and

(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 an IRO, including the address and telephone number of the MHCBC of the OSI, 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.

**C.** With each notice of a rescission of coverage or final adverse benefit determination, the health care insurer shall provide written notice of the grievant's right for an independent review of the determination by an IRO.

**D.** The notice referenced above in Subsection C shall include the following statement: *"We have rescinded your coverage or denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by a health care professional who has no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested. To receive additional information about an independent review, contact OSI by phone at: (505) 827-3928 or by electronic mail at: mhcb.grievance@state.nm.us. You may also find additional information at the OSI website at: <http://www.osi.state.nm.us/>."*

[13.10.17.22 NMAC - Rp, 13.10.17.21 NMAC, 1/1/16]

### **13.10.17.23 INDEPENDENT REVIEW ORGANIZATIONS (IRO):**

**A.** The superintendent shall compile and maintain a list of approved IROs.

**B.** To be considered for placement on the list of approved IROs, an IRO shall:

- (1) be accredited by a nationally recognized private accrediting entity;
- (2) meet the requirement of this rule; and
- (3) have written policies and procedures that ensure:
  - (a) all reviews are conducted within a specific time frame;
  - (b) the selection of qualified and impartial clinical reviewers;
  - (c) the confidentiality of medical and treatment records and clinical

review criteria; and

(d) that any person employed by or under contract with the IRO adheres to the requirements of this rule.

**C.** An applicant requesting placement on the list of approved IROs shall submit for the superintendent's review:

(1) an IRO application form available on the OSI website at:  
<http://www.osi.state.nm.us/>;

(2) all documentation and information requested on the application, including proof of being accredited by a nationally recognized private accrediting entity; and

(3) the application fee to be set by the superintendent.

**D.** The superintendent shall, in the superintendent's sole discretion, terminate the approval of an IRO if the superintendent determines that the RO has lost its accreditation or no longer satisfies the minimum requirements for approval.

**E.** An IRO assigned to conduct the independent review may not have a material, professional, familial or financial conflict of interest with:

- (1) the health care insurer;
- (2) an officer, director, manager or management employee of the health care insurer;
- (3) the health benefit plan;

- (4) the plan administrator, plan fiduciaries or plan employees;
  - (5) the grievant;
  - (6) the grievant's health care provider(s);
  - (7) the health care provider's medical group or independent practice association;
  - (8) a health care facility where the service would be provided; or
  - (9) the developer or manufacturer of the service that would be provided.
- F.** An IRO shall keep and maintain written records and make available upon request to OSI, any record for which it conducted an external review.
- G.** An IRO shall keep and maintain written records organized by health care insurer and make available to OSI every calendar year on January 15, a report which includes:
- (1) the total number of external reviews conducted and organized by health care insurer;
  - (2) the number of external reviews resolved; and of those resolved, the number resolved upholding the adverse determination or final adverse determination of the health care insurer;
  - (3) the total number resolved reversing the adverse determination or final adverse determination of the health care insurer;
  - (4) the average length of time for the review;
  - (5) a summary of the types of coverages or cases for which the external review was sought, as provided in the format required by the superintendent;
  - (6) the number of external reviews that were terminated as a result of a reconsideration by the health care insurer of its adverse determination or final adverse determination after the receipt of additional information from the grievant; and
  - (7) any other information the superintendent may request or require.
- H.** An IRO must maintain written records required pursuant to this rule for at least five years.

[13.10.17.23 NMAC - N, 1/1/16]

**13.10.17.24 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS BY AN IRO:**

- A. Right to external review.** Every grievant who is dissatisfied with the results of an internal or 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 an IRO appointed by the superintendent from the list of approved IROs, at no cost to the grievant, and on an impartial, rotational basis:
- (1) there shall be no minimum dollar amount of a claim before a grievant may exercise this right to external review;
  - (2) the health care insurer must pay for the external review of the adverse determination by the IRO; and
  - (3) the health care insurer must include a description of the external review process in or attached to the summary plan description, policy certificate, membership booklet, outline of coverage or other evidence of coverage it provides to participants, beneficiaries or enrollees that provides a statement that informs the grievant the grievant's right to file a request for an external review of an adverse determination or final adverse determination with the superintendent; the statement should explain that an external review is available when the

adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; the statement shall include:

- (a) the following telephone number: (505) 827-3928; and
- (b) the following address of the superintendent: superintendent of insurance, attn: managed health care bureau - external review request, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689; or 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) 827-6341; or
- (d) completed on-line with an OSI complaint form available at <http://www.osi.state.nm.us/>.

**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 review process by failing to comply with the requirements of the internal appeals process; or
- (3) the grievant simultaneously requests an expedited internal review and an expedited external review by an IRO.

**D. Exception to exhaustion requirement.**

(1) Notwithstanding Subsection B of 13.10.17.24 NMAC, 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 on-going, good faith exchange of information between the health care insurer 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 as determined by the superintendent.

(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 with 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 13.10.17.24 NMAC on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of 13.10.17.24 NMAC, the grievant has the right to re-submit 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 re-submit 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.



**E. Compliance.** An adverse benefit determination procedure shall be compliant with this rule and with the requirements for adverse benefit determinations set forth in 29 CFR 2560.503-1 and 45 CFR 147.136.

[13.10.17.24 NMAC - Rp, 13.10.17.23 NMAC, 1/1/16]

### **13.10.17.25 FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS BY AN IRO:**

#### **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 MHCB at (505) 827-3928 or 1-877-673-1732.

(2) **In all other cases.** To initiate an external review by an IRO, a grievant must file a written request for external review with the superintendent within 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, office of superintendent of insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689; or

(b) e-mailed to mhcb.grievance@state.nm.us, subject: external review request; or

(c) faxed to the superintendent of insurance, attn: managed health care bureau - external review request at (505) 827-6341; or

(d) completed on-line with an OSI complaint form available at <http://www.osi.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:

(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 13.10.17.29 NMAC.

**C. Other filings.** Within five days, the grievant may also file any other supporting documents or information the grievant wishes to submit to the IRO for review. The IRO must send any additional information from grievant to the health care insurer within one business day.

[13.10.17.25 NMAC - Rp, 13.10.17.24 NMAC, 1/1/16]

### **13.10.17.26 ACKNOWLEDGEMENT BY THE SUPERINTENDENT OF REQUEST FOR EXTERNAL REVIEW OF ADVERSE DETERMINATION BY AN IRO AND COPY TO HEALTH CARE INSURER:**

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

(1) assign, on a random basis, an IRO from the list of approved IROs based on the nature of the health care service that is the subject of the review;

(2) send the grievant a notice that the request has been received and an IRO assigned, and inform the claimant that the health care insurer will provide all documents listed in Paragraphs (1) thru (5) of Subsection B below, and the grievant may submit additional information to the IRO within five working days of the receipt of the notice; and

(3) send the health care insurer a copy of the request for external review and IRO assigned.

**B.** Upon receipt of the copy of the request for external review, the health care insurer shall, within five working days for standard review or the time limit set by the superintendent for expedited review, provide to the IRO and the grievant by any available expeditious method, the documents and any information considered in making the adverse benefit determination including:

(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 reviewing hearing.

**C.** Within one business day, the IRO shall forward to the health care insurer, any copies of any documents and information submitted by the grievant.

**D.** If the health care insurer fails to comply with the requirements of Subsection B of 13.10.17.26 NMAC, the superintendent may reverse the adverse determination.

[13.10.17.26 NMAC - Rp, 13.10.17.25 NMAC, 1/1/16]

### **13.10.17.27 TIME FRAMES FOR EXTERNAL REVIEW OF ADVERSE**

**DETERMINATIONS BY AN IRO:** The IRO 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 IRO shall complete an external review as required by the medical exigencies of the case as soon as possible, but in no case later than 72 hours of receipt of the external review appointment by the superintendent, whenever:

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

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

(c) in the opinion of the grievant's attending provider, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination.

(2) upon receipt of the superintendent's notice that an IRO has been appointed, the health care insurer shall within one working day provide to the assigned IRO, all

documents and information considered in making the adverse benefit determination as described in Subsection B of 13.10.17.26 NMAC;

(3) within one day from the date of the notice from the superintendent that the IRO has been appointed, the grievant may submit additional documentation or information to the IRO and the IRO shall forward copies of the documentation or information received from the grievant to the health care insurer within one business day from receipt of any documentation or information from the grievant.

**B. Standard review.** The IRO shall conduct a standard review in all cases not requiring expedited review. The IRO shall complete the initial review within 10 working days from receipt of the appointment for external review, and from receipt of the information required of the grievant and health care insurer in Subsection B of 13.10.17.25 and Subsection B of 13.10.17.26 NMAC respectively.

**C.** Any request for independent external review sent to the health care provider instead of to the superintendent, shall be forwarded to the superintendent by the health insurance provider within one business day of receipt.

[13.10.17.27 NMAC - Rp, 13.10.17.26 NMAC, 1/1/16]

### **13.10.17.28 CRITERIA FOR EXTERNAL REVIEW OF ADVERSE**

**DETERMINATION BY AN IRO:** Upon receipt of the request for external review, OSI staff shall review the request to determine whether:

**A.** The grievant has provided the documents required by Subsection B of 13.10.17.25 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.

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

[13.10.17.28 NMAC - Rp, 13.10.17.27 NMAC, 1/1/16]

### **13.10.17.29 ADDITIONAL CRITERIA FOR EXTERNAL REVIEW OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT ADVERSE**

**DETERMINATIONS BY AN IRO:** If the request is for external review of an experimental or investigational treatment adverse determination, the IRO 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.

**B. Medical necessity:** The grievant's treating provider has certified that:  
(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.

[13.10.17.29 NMAC - Rp, 13.10.17.28 NMAC, 1/1/16]

### **13.10.17.30 THE FINAL DECISION OF THE IRO AND GRIEVANT'S RIGHT TO HEARING AFTER FINAL IRO DECISION:**

A. The decision of the IRO is binding upon the health care insurer as well as grievant except to the extent that New Mexico law allows grievant to appeal to the superintendent for a hearing pursuant the Patient Protection Act, Section 59A-57-1 NMSA 1978 *et seq.* This requirement that the decision is binding shall not preclude the health care insurer from making payment on the claim or otherwise providing benefits at any time, including after final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the health care insurer must provide benefits (including making payment on the claim) pursuant to the final external review decision with delay, regardless of whether the health care insurer intends to seek judicial review of the external review decision and unless or until there is a final judicial decision otherwise.

B. If grievant is dissatisfied with the denial of benefits by the IRO, grievant may request a hearing from the superintendent.

C. The superintendent will automatically grant the hearing.

D. The health care insurer will be responsible for paying for all costs associated with the hearing.

[13.10.17.30 NMAC - N, NMAC, 1/1/16]

### **13.10.17.31 HEARING PROCEDURES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:**

A. **Conduct of hearing.** The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at OSI's expense.

B. **Co-hearing officers.** The superintendent may designate two ICOs who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. If the superintendent designates two ICOs, 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 ICOs.

**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 OSI'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 MHC 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.

**I. Self-insured plan representative.** If a grievant is insured pursuant to the Health Care Purchasing Act, and the grievant requests a hearing, if a representative from the self-insured plan is not present at any pre-hearing conference or at the hearing required by OSI, the health care insurer will be deemed to speak on behalf of the self-insured plan.

**J. Decision.** A decision shall be issued by the co-hearing officers within 20 working days from the date of the conclusion of the hearing.

[13.10.17.31 NMAC - Rp, 13.10.17.30 NMAC, 1/1/16]

### **13.10.17.32 INDEPENDENT CO-HEARING OFFICERS (ICOS):**

**A. Identification of ICOs.** The superintendent shall provide for maintenance of a list of licensed professionals qualified to service as ICOs. The superintendent shall select appropriate professional societies, organizations or associations to identify licensed health care and other professionals who are willing to serve as ICOs 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 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 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 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 years and make them available upon request to the state.  
[13.10.17.32 NMAC - Rp, 13.10.17.31 NMAC, 1/1/16]

#### **13.10.17.33 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 prepared 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 time frame for compliance.

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

[13.10.17.33 NMAC - Rp, 13.10.17.32 NMAC, 1/1/16]

#### **13.10.17.34 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 working days after receipt of an administrative grievance, the health care insurer shall send the grievant a written acknowledgment that it 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.

[13.10.17.34 NMAC - Rp, 13.10.17.33 NMAC, 1/1/16]

### **13.10.17.35 INITIAL INTERNAL REVIEW DECISION ON ADMINISTRATIVE**

**GRIEVANCE:** The health care insurer shall mail a written decision to the grievant within 15 working days of receipt of the administrative grievance. The 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 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.

[13.10.17.35 NMAC - Rp, 13.10.17.34 NMAC, 1/1/16]

### **13.10.17.36 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 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 10 working days in advance. The notice shall advise the grievant of

the rights specified in Subsection E of 13.10.17.36 NMAC. If the health care insurer will have an attorney represent its 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.

**D. Information to grievant.** No fewer than three 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.

[13.10.17.36 NMAC - Rp, 13.10.17.35 NMAC, 1/1/16]

**13.10.17.37 DECISION OF RECONSIDERATION COMMITTEE:** The health care insurer shall mail a written decision to the grievant within seven 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 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.

[13.10.17.37 NMAC - Rp, 13.10.17.36 NMAC, 1/1/16]

**13.10.17.38 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

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

**D. Exception to exhaustion requirement.**

(1) Notwithstanding Subsection B of 13.10.17.38 NMAC, 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 on-going, 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 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 13.10.17.38 NMAC on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of 13.10.17.38 NMAC, the grievant has the right to re-submit 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 re-submit 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.

[13.10.17.38 NMAC - Rp, 13.10.17.37 NMAC, 1/1/16]

**13.10.17.39 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 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, office of superintendent of insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689; or

(2) e-mailed to mhcb.grievance@state.nm.us, subject: external review request; or

(3) faxed to the superintendent of insurance, attn: managed health care bureau - external review request at (505) 827-6341; or

(4) completed on-line using an OSI complaint form available at <http://www.osi.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 13.10.17.37 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 time frames for external review.** If a grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the time frames 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. [13.10.17.39 NMAC - Rp, 13.10.17.38 NMAC, 1/1/16]

**13.10.17.40 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; and
- (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 working days all necessary documents and information considered in arriving at the administrative grievance decision.

[13.10.17.40 NMAC - Rp, 13.10.17.39 NMAC, 1/1/16]

**13.10.17.41 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 20 working days of receipt of the complete request for external review in compliance with 13.10.17.40 NMAC.

[13.10.17.41 NMAC - Rp, 13.10.17.40 NMAC, 1/1/16]

**HISTORY OF 13.10.17 NMAC:**

**NMAC history:**

13.10.17 NMAC, Grievance Procedures, effective 7/1/2000.

13.10.17 NMAC, Grievance Procedures, effective 3/31/2004

13.10.17 NMAC, Grievance Procedures, effective 2/1/2008.

**History of repealed material:**

13 NMAC 10.17, Grievance Procedure for Enrollees Covered by Risk Management Division, filed 11/02/98 - Repealed effective 7/1/2000.

13.10.17 NMAC, Grievance Procedures, filed 6/14/2000 - Repealed effective 3/31/2004.

13.10.17 NMAC, Grievance Procedures, filed 3/12/2004 - Repealed effective 1/1/2016.