

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, 1/1/17]

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

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; or
(3) self-funded plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

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, 1/1/17]

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, 1/1/17]

13.10.17.4 DURATION: Permanent.

[13.10.17.4 NMAC - Rp, 13.10.17.4 NMAC, 1/1/17]

13.10.17.5 EFFECTIVE DATE: January 1, 2017, unless a later date is cited at the end of a section.

[13.10.17.5 NMAC - Rp, 13.10.17.5 NMAC, 1/1/17]

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, 1/1/17]

13.10.17.7 DEFINITIONS: As used in this rule:

A. “Administrative decision” means a decision made by a health care insurer regarding any aspect of a health benefits plan other than an adverse determination, including but not limited to:

- (1) administrative practices of the health care insurer that affect the availability, delivery, or quality of health care services;
- (2) claims payment, handling or reimbursement for health care services, including but not limited to complaints concerning co-payments, co-insurance and deductibles; and
- (3) terminations of coverage.

B. “Administrative grievance” means an oral or written complaint submitted by or on behalf of a covered person regarding an administrative decision.

C. “Adverse determination” means any of the following:

- (1) any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time);

(2) a denial, reduction, or termination of, or a failure to make full or partial payment for a benefit including any such denial, reduction, termination, or failure to make payments, that is based on a determination of a covered person's eligibility to participate in a health benefits plan; or

(3) a denial, reduction or termination of, or a failure to make full or partial payment for a benefit resulting from the application of any utilization review; or

(4) 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.

D. "Adverse determination grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding an adverse determination.

E. "Certification" means a determination by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for determining medical necessity, appropriateness, health care setting, level of care and effectiveness, and the requested health care service is therefore approved.

F. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state in the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

G. "Co-insurance" is a cost-sharing plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid; co-insurance rates may differ for different types of services.

H. "Co-payment" is a cost-sharing plan that requires an insured person to pay a fixed dollar amount when a medical service is received or when purchasing medicine after the deductible amount, with the health care insurer paying the balance; there may be different co-payments for different types of service.

I. "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan.

J. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

K. "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 the telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and reviews (including IRO reviews and external reviews) 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.

L. "Day or Days" shall be interpreted as follows, unless otherwise specified:

(1) 1-5 days means only working days and excludes weekends and state holidays; and

(2) 6 days or more means calendar days, including weekends and holidays.

M. "Deductible" means a fixed dollar amount that the covered person may be required to pay during the benefit period before the health care insurer begins payment for covered benefits; plans may have both individual and family deductibles and separate deductibles for specific services.

N. "Expedited review" means a review with a shortened timeline, as described in sections 13.10.17.14 NMAC, 13.10.17.16 NMAC, 13.10.17.21 NMAC, 13.10.17.22 NMAC, and 13.10.17.24 NMAC, which is required in urgent care situations or when the grievant is receiving an on-going course of treatment which the health care insurer seeks to reduce or terminate.

O. "External review" means the external review conducted pursuant to this rule by the superintendent or by an IRO appointed by the superintendent, depending on the circumstances.

P. “**Final adverse determination**” means an adverse determination that has been upheld by a health care insurer at the conclusion of the internal review process.

Q. “**Grievance**” means an oral or written complaint submitted by or on behalf of a covered person regarding either an adverse determination or an administrative decision.

R. “**Grievant**” means a covered person or that person’s authorized representative, provider or other health care professional with knowledge of the covered person’s medical condition, acting on behalf of and with the covered person’s consent.

S. “**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, including a traditional fee-for-service health benefits plan and coverage provided by, through or on behalf of an entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act.

T. “**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 benefits plan, fraternal benefit society, vision plan or pre-paid dental plan.

U. “**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.

V. “**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.

W. “**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 external review hearings.

X. “**Independent review organization (IRO)**” means an entity that is appointed by the superintendent to conduct independent external reviews of adverse determinations and final adverse determinations pursuant to this rule; and which renders an independent and impartial decision.

Y. “**Initial determination**” means a formal written disposition by a health care insurer affecting a covered person’s rights to benefits, including full or partial denial of a claim or request for coverage or its initial administrative decision.

Z. “**Managed health care bureau (MHCB)**” means the managed health care bureau within the office of the superintendent of insurance.

AA. “**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.

BB. “**Office of the superintendent of insurance (OSI)**” means the office of the superintendent or its staff.

CC. “**Post-service claim**” means a claim submitted to a health care insurer by or on behalf of a covered person after health care services have been provided to the covered person.

DD. “**Prior authorization**” (also called pre-certification) means a pre-service determination made by a health care insurer regarding a member’s eligibility for services, medical necessity, benefit coverage, location or appropriateness of services, pursuant to the terms of the health care plan.

EE. “**Prospective review**” means utilization review conducted prior to provision of health care services in accordance with a health care insurer’s requirement that the services be approved in advance.

FF. “**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.

GG. “**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; or

(3) the cancellation or discontinuance of coverage is initiated by the covered person or the covered person's authorized representative and the employer or health care insurer did not, directly or indirectly, take action to influence the covered person's decision or otherwise retaliate against, interfere with, coerce, threaten or intimidate the covered person; or

(4) the cancellation or discontinuance is initiated by the health insurance exchange.

HH. "Retrospective review" means utilization review that is not conducted prior to provision of health care services.

II. "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.

JJ. "Superintendent" means the superintendent of insurance, or the office of the superintendent of insurance.

KK. "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, termination initiated by the health insurance exchange, or termination of a health benefits plan that does not contain a renewal provision.

LL. "Traditional fee-for-service indemnity benefit" means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered person 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.

MM. "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.

NN. "Urgent care situation" means a situation in which the decision regarding certification of coverage shall be expedited because:

(1) the life or health of a covered person would otherwise be jeopardized;

(2) the covered person's ability to regain maximum function would otherwise be jeopardized;

(3) the physician with knowledge of the covered person's medical condition **reasonably** requests an expedited decision;

(4) in the opinion of the physician with knowledge of the covered person's medical condition, delay would subject the covered person 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 covered person's claim otherwise involves urgent care.

OO. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

[13.10.17.7 NMAC - Rp, 13.10.17.7 NMAC, 1/1/17]

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 days after the date it was mailed.

[13.10.17.8 NMAC - Rp, 13.10.17.8 NMAC, 1/1/17]

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 that comply with this rule to provide for the internal review of adverse determination grievances and administrative grievances.

B. Divisible grievance. If a grievance contains clearly divisible administrative and adverse determination 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.

C. Assistance to grievants. In those instances, where a grievant requests or expresses interest in pursuing a grievance, the health care insurer shall assist the grievant to complete all the forms required to pursue internal review and shall advise grievant that the MHCB is available for assistance.

D. 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, 1/1/17]

13.10.17.10 INFORMATION ABOUT GRIEVANCE PROCEDURES:

A. For covered persons/grievants. A health care insurer shall:

(1) include a clear and concise summary of the grievance procedures, both internal and external, in boldface type in all handbooks or evidences of coverage, issued to covered persons, along with a link to the full version of the grievance procedures, as found on the OSI website;

(2) when the health care insurer makes either an initial or final adverse determination or an administrative decision, provide the following to a covered person, that person's authorized representative or a provider acting on behalf of a covered person:

(a) a concise written summary of its grievance procedures;

(b) a copy of the applicable grievance forms;

(c) a link to the full version of the grievance procedures, as found on the OSI website; and

(d) a toll-free telephone number, facsimile number, e-mail and mailing addresses of the health care insurer's consumer assistance office and for the MHCB.

(3) notify covered person that a representative of the health care insurer and the MHCB are available upon request to assist covered person 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 covered person;

(4) make available on its website or upon request, consumer education brochures and materials developed and approved by the superintendent in consultation with the health care insurer;

(5) provide notice to covered person in a culturally and linguistically appropriate manner as defined in Subsection H of 13.10.17.7 NMAC;

(6) provide continued coverage for an approved on-going course of treatment pending the final determination on review;

(7) not reduce or terminate an approved on-going course of treatment without first notifying the grievant sufficiently in advance of the reduction or termination to allow a covered person to request a review and obtain a final determination on review of the proposed reduction or termination; and

(8) allow covered person in urgent care situations and those receiving an on-going course of treatment that the health care insurer seeks to reduce or terminate to proceed with an expedited IRO 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 and shall make all necessary forms available upon request, including consumer education brochures and materials developed or approved by the superintendent for distribution. These items may be provided in paper format or electronically.

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, and MHCB, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.

[13.10.17.10 NMAC - N, 13.10.17.10 NMAC, 1/1/17]

13.10.17.11 INITIAL DETERMINATIONS:

A. Expedited initial decision. A health care insurer shall make its initial certification or adverse determination decision in urgent care situations in accordance with the medical exigencies of the case. The health care insurer shall make decisions within 24 hours after receipt of the request for an expedited decision. An expedited decision is not available for post-service claims.

B. Standard initial decision. A health care insurer shall make all other initial utilization review decisions within five days after receipt of the request. The health care insurer may extend the review period for a maximum of 10 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 covered person; and
- (3) provides a written progress report and explanation for the delay to the covered person and provider within the original five-day review period.

C. Coverage. When considering whether to certify a health care service requested by a provider or covered person, the health care insurer shall determine whether the requested health care service is covered by the health benefits plan. Before denying a requested health care service 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.

D. 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 requested health care service, the health care insurer shall assign a physician, registered nurse, or other health care professional to determine, within the timeframe required by the medical exigencies of the case, 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 covered person on grounds that it is determined to be not medically necessary, experimental, or investigational a physician shall render an opinion, 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 covered person.

E. Incomplete information. If the covered person fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the health benefits plan, the covered person shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than two days, to provide the specified information.

(1) **Expedited initial decision.** If the covered person has been afforded time to provide additional information, then the health care insurer shall have 24 hours after the additional information is received to make its determination.

(2) **Standard initial decision.** If the covered person has been afforded time to provide additional information, then the health care insurer shall have five days after the additional information is received to make its determination.

[13.10.17.11 NMAC - Rp, 13.10.17.15 NMAC, 1/1/17]

13.10.17.12 NOTICE OF INITIAL DETERMINATION:

A. Certification. The health care insurer shall send written notice to the covered person and provider of the certification by mail or electronic communication within one day after the date the health care service was certified, unless earlier notice is required by the medical exigencies of the case.

B. Notice of adverse determination or administrative decision; explanatory contents. The health care insurer shall notify a covered person and provider of an adverse determination by telephone or as required by the medical exigencies of the case, but in no case later than one day after making the adverse determination. Additionally, the health care insurer shall notify the covered person and provider of the adverse determination or administrative decision in writing by mail or electronic communication sent within one day after the telephone notice.

C. Contents of notice of initial adverse determination or administrative decision.

(1) The notices required in Paragraph C, Subparagraphs (2) and (3) of Section 13.10.17.12 shall be provided to the covered person, the covered person's authorized representative, if applicable, and to a provider or other health care professional with knowledge of the covered person's medical condition.

(2) **Adverse determination.**

(a) If an adverse determination is based on a determination that the requested service is experimental, investigational or not medically necessary, clearly and completely explain why the requested health care service is not medically necessary or is experimental or investigational; a statement that the health care service is not medically necessary, is experimental, or is investigational will not be sufficient.

(b) If an 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.

(c) If the service has already been provided, then include the date of service, the 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.

(d) Include a description of the health care insurer's standard that was used in denying the claim.

(e) Provide information stating that a request for review of an adverse determination must be filed with the health care insurer within 180 days.

(f) If the adverse determination involves an urgent care situation, provide information that an expedited IRO review to be conducted at the same time as an expedited internal review may be requested.

(g) Describe the procedures and provide all necessary grievance forms for requesting internal review of the decision.

(3) Administrative decision.

(a) If the decision involves claims payment, handling or reimbursement for health care services, identify the provisions of the plan that were relied upon in making the decision, including cost-sharing provisions such as co-payments, co-insurance and deductibles.

(b) If the decision involves termination of coverage, identify the provisions of the plan that were relied upon in making the determination.

(c) If the service has already been provided, then include the date of service, the 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.

(d) Provide information that a request for an internal review of an administrative decision must be filed with the health care insurer within 180 days.

(e) Describe the procedures and provide all necessary grievance forms for requesting internal review of the decision.

[13.10.17.12 NMAC - Rp, 13.10.17.16 NMAC, 1/1/17]

13.10.17.13 PRELIMINARY DETERMINATION OF GRIEVANCE: 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, 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 13.10.17.14 NMAC through 13.10.17.26 NMAC 1978.

B. If the grievance is not based on an adverse determination, it is an administrative grievance and the health care insurer shall reconsider the decision in accordance with its procedures for administrative grievances and the requirements of 13.10.17.27 NMAC through 13.10.17.33 NMAC.

[13.10.17.13 NMAC - N, 1/1/17]

13.10.17.14 INTERNAL FIRST LEVEL 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 within 180 days of the date of the adverse determination. Nothing in this rule precludes the health care insurer and grievant from resolving a request prior to completion of the internal review.

B. Acknowledgement of request. Upon receipt of a request for first level internal review of an adverse determination, the health care insurer shall date and time stamp the request, and within three days after 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:

(1) allow the grievant to review the claim file;

(2) allow the grievant to present evidence and submit evidence, including but not limited to written comments, documents, records and other materials relating to the request for benefits;

(3) as soon as possible but no less than five days in advance of the date of the internal review of adverse benefit determination, provide the grievant, free of charge, with:

(a) copies of all documents, policies, guidance, statements, records and other information relevant to the request for benefits; and

(b) all evidence or rationale, considered, relied upon, or generated by the health care insurer.

(4) allow the grievant a reasonable opportunity to respond before the adverse determination is reviewed and if the evidence or rationale is not provided to the grievant in time for the grievant to have a reasonable opportunity to respond, provide additional time at the grievant's request in order for the grievant to prepare a response.

D. Conflict of interest. The health care insurer must ensure that all claims and internal reviews are handled in a manner designed to ensure the independence and impartiality of the person(s) 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 a medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

E. Utilization review. In the case of an adverse determination involving utilization review, the health care insurer shall designate one or more appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer(s) shall not have been involved in the initial adverse determination. If more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination shall be health care professionals who have appropriate expertise.

F. Timeframe for internal reviews 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 internal review, as appropriate.

(1) **Expedited internal review.** Whenever a request involves an urgent care situation, 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.

(2) **Standard internal review.** In all cases that do not require expedited review, both the standard first level internal review and, if requested, the internal panel's review, as described in 13.10.17.16 NMAC, shall be completed within 30 days after receipt of a request for internal review conducted prior to service and within 60 days after receipt of a request involving a post-service claim.

(a) The timeframe for completing an internal panel review may be extended, at the grievant's request, to afford the grievant a reasonable opportunity to respond to any new or additional rationale or evidence provided to the grievant by the health care insurer during the internal review process.

(b) The health care insurer shall not unreasonably deny a request by the grievant to postpone the internal panel review for up to 30 days.

(c) The timeframe for completing both internal reviews shall be extended during the period of any such postponement.

(d) The health care insurer shall have three days after concluding the postponed internal review to issue its determination.

G. Additional requirements for expedited internal review of an adverse determination.

(1) In an expedited review, all information required to be exchanged shall be transmitted between the health care insurer and the grievant by the most expedient method available.

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

(3) 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.

H. Failure to comply with deadline. If the health care insurer fails to comply with the deadline for completion of an internal review, unless such deadline is postponed by the grievant, the requested health care service shall be deemed approved, provided that the requested health care service reasonably appears to be a covered benefit under the applicable health benefits plan.

I. New Mexico Health Care Purchasing Act. For grievants who are covered under the New Mexico Health Care Purchasing Act, the health care insurer must provide both a first level review and a review by a panel.

[13.10.17.14 NMAC - Rp, 13.10.17.17 NMAC, 1/1/17]

13.10.17.15 NOTICE FOLLOWING FIRST LEVEL INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Notice requirements. The health care insurer shall notify the grievant and provider of the decision within 24 hours by telephone and in writing by mail or electronic communication sent within one day after the initial attempt to provide telephonic notice, unless earlier notice is required by the medical exigencies of the case.

B. Contents of notice. If the initial decision denying certification is upheld in whole or in part, then the health care insurer's notice shall include the following:

- (1) the name, title and qualifying credentials of the person who provided the review;
- (2) a statement of the reviewer's understanding of the nature of the grievance;
- (3) a description of the evidence relied on by the reviewer in reaching a decision;
- (4) if an adverse determination is upheld based on a determination that the requested service is experimental, investigational or not medically necessary, then:
 - (a) clearly and completely explain why the requested health care service is not medically necessary, is experimental or investigational; a statement that the health care service is not medically necessary, is experimental or investigational will not be sufficient; and
 - (b) include a citation to the uniform standards relevant to the grievant's medical condition and an explanation of whether each standard supported or did not support the determination that the requested service is experimental, investigational, or is not medically necessary.
- (5) if an adverse determination is upheld 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;
- (6) if the service has already been provided, then include the date of service, the 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;
- (7) notice that the grievant may request either:
 - (a) an internal panel review within five days; or
 - (b) an external review within four months.
- (8) if the adverse determination involves an urgent care situation, advise that the grievant may immediately request an expedited IRO external review;
- (9) if the grievant is covered by the New Mexico Health Care Purchasing Act, then advise the grievant that an internal panel review is required before the grievance will be reviewed by the grievant's specific review board and only then may the grievant request an external review; and
- (10) describe the procedures and provide all necessary grievance forms to the grievant for requesting an internal panel review, for requesting an external review, or for requesting an expedited review.

C. Information for requesting an external review. Notice of the grievant's right to request an external review shall include the address and telephone number of the MHCB, a description of all procedures and time deadlines necessary to pursue an external review, copies of all forms required to initiate an external review and the following notice:

"We have 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, at no cost to you, by an impartial Independent Review Organization (IRO) who has no association with us and is appointed by the Office of Superintendent of Insurance (OSI). If our decision involved making a judgment as to the medical necessity, experimental nature or investigational nature of the requested service, or the appropriateness, health care setting, or level of care, then the IRO review will be performed by one or more health care professionals. You may also request an external review by OSI for rescissions or for adverse determinations that do not involve medical judgment. For more information contact OSI by electronic mail at mhcb.grievance@state.nm.us; by telephone at (505) 827-4601; or toll-free at 1-(855)-427-5674. You may also visit the OSI website at <http://www.osi.state.nm.us> for more information."

D. Grievance discontinued. If the grievant informs the health care insurer by telephone that the grievant does not wish to pursue the grievance, then the health care insurer's notice shall include confirmation of the grievant's decision not to pursue the matter further.

E. Grievant's decision unknown. If the health care insurer is unable to contact the grievant by telephone within one day of the decision to uphold the adverse determination, the health care insurer's written notice shall include a self-addressed stamped envelope and response form which asks whether the grievant wishes to request either an internal panel review or an external review. The form shall provide check boxes as follows:

Do you want to appeal the decision?

No

Yes (If yes, then please select one of the following:)

Internal panel review requested

External review requested

F. Extending the timeframe for requesting a 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 F of 13.10.17.14 NMAC, the timeframe shall be extended to include the additional time if requested by the grievant.
[13.10.17.15 NMAC - N, 1/1/17]

13.10.17.16 INTERNAL PANEL REVIEW OF ADVERSE DETERMINATIONS:

A. Applicability of internal panel review.

(1) A health care insurer that offers managed health care plans shall establish a panel review process for its managed health care plans to give those grievants who are dissatisfied with the internal review decision the option to request a panel review, at which the grievant has the right to appear in person before a panel of designated representatives of the health care insurer.

(2) This section also applies to persons covered under the New Mexico Health Care Purchasing Act (public employees and retirees, public school employees and retirees only).

B. Acknowledgment of request. Upon receipt of a request for internal panel review of an adverse determination, the health care insurer shall date and time stamp the request and:

(1) for a standard internal panel review, within three working days after receipt of the request, send the grievant an acknowledgment that the request has been received; or

(2) for an expedited internal panel review, acknowledge the request telephonically or by electronic communication; and

(3) the acknowledgment shall:

(a) contain the name, address and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the grievance;

(b) specify the date, time and location for the internal panel review meeting and provide a toll-free number for the grievant to participate telephonically;

(c) include the grievant's rights as set forth below; and

(d) inform the grievant if the health care insurer will be represented by an attorney.

C. Grievant's rights. The health care insurer shall notify the grievant of the grievant's right to:

(1) request the opportunity to appear in person or telephonically before an internal review panel comprised of the health care insurer's designated representatives;

(2) present the grievant's case to the internal review panel orally or in writing;

(3) submit written comments, documents, records, and other material relating to the request for benefits for the internal review panel to consider when conducting the review both before and, if applicable, at the review panel's meeting;

(4) if applicable, ask questions of any representative of the health care insurer or health care professional on the internal review panel;

(5) be assisted or represented by an individual of the grievant's choice, including legal representation at the grievant's expense;

(6) hire a specialist to participate in the internal panel review at the grievant's expense, but such specialist may not participate in making the decision; and

(7) request a postponement of the internal panel review for up to 30 days.

D. Conduct of the internal panel review.

(1) Upon receipt of a grievant's request for an internal panel review, the health care insurer shall appoint a panel to review the request.

(a) The health care insurer shall select representatives of the health care insurer and if the adverse determination was based on a determination that the requested service is not a medical necessity, is experimental or investigational, or is considered not a covered benefit, one or more qualified health care professionals shall serve on the internal review panel. At least one of the health care professionals selected shall be a clinical peer that practices 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.

(b) A panel shall be comprised of individuals who have no financial interest in the outcome of the review and who were not involved in the initial determination or the first internal review decision, except that an individual who was involved in the first internal review decision may appear before the panel to present information or answer questions.

(2) In conducting the review, the internal review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the grievant, without regard to whether the information was submitted or considered in reaching the initial determination or the first internal review decision.

(3) The internal review panel shall have the legal authority to bind the health care insurer to the panel's decision.

(4) If the initial adverse determination was based on a lack of 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. If the internal review panel finds that the requested health care benefit is not covered by the health benefits plan, the panel shall issue its final adverse determination in accordance with this rule.

(5) If the initial adverse determination was based on a determination that the requested service is experimental, investigational or not a medical necessity, the internal review panel shall render an opinion, 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.

(6) Internal review panel members must be physically present or attend the panel by video or telephone conferencing to participate in the decision.

E. Information to grievant. No fewer than three days prior to the internal panel review, the health care insurer shall provide to the grievant copies of all documents that will be considered in reviewing the grievant's request for benefits, including, if applicable:

- (1) the grievant's pertinent medical records;
- (2) the treating provider's recommendation;
- (3) relevant sections of 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 shall be 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 for up to 30 days made by the grievant. The timeframes for completing the internal panel review shall be extended during the period of any postponement.

G. Additional requirements for expedited internal panel review of an adverse determination.

(1) In an expedited review, all information required to be exchanged by Section E. of 13.10.17.16 NMAC shall be transmitted between the health care insurer and the grievant by the most expedient method available.

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

(3) A health care insurer shall not conduct an expedited internal panel review of post-service claims.

[13.10.17.16 NMAC - Rp, 13.10.17.20 NMAC, 1/1/17]

13.10.17.17 NOTICE OF INTERNAL PANEL REVIEW DECISION:

A. Notice requirements. The health care insurer shall notify the grievant and provider of the internal panel's decision within 24 hours by telephone and in writing by mail or electronic communication sent within one day after the initial attempt to provide telephonic notice, unless earlier notice is required by the medical exigencies of the case.

B. Contents of notice. If the initial decision denying certification is upheld in whole or in part, then the panel's 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 review 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) if an adverse determination is upheld based on a determination that the requested service is experimental, investigational or not medically necessary, then:
 - (a) clearly and completely explain why the requested health care service is not medically necessary, is experimental or investigational; a statement that the health care service is not medically necessary, is experimental or investigational will not be sufficient; and
 - (b) include a citation to the uniform standards relevant to the grievant’s medical condition and an explanation of whether each supported or did not support the decision regarding a determination that the requested service is experimental, investigational, or medically necessary.
- (5) if an adverse determination is upheld 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;
- (6) if the service has already been provided, then include the date of service, the 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;
- (7) if the grievant is covered by the New Mexico Health Care Purchasing Act, then advise the grievant of the grievant’s right to request review from and in the manner designated by an entity authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act and that the entity must review the grievant’s request before grievant can request an external review;
- (8) if the adverse determination involved medical judgment, including a determination based on medical necessity, appropriateness, health care setting, level of care, effectiveness or that the requested health care service is experimental or investigational, notice of the grievant’s right to request external review by an IRO within four months, including the address and telephone number of the MHCB, a description of all procedures necessary to pursue an IRO external review, copies of any forms required to initiate an IRO external review; or
- (9) if the adverse determination did not involve medical judgment, notice of the grievant’s right to request external review by the superintendent and copies of any forms required to initiate an external review by the superintendent.

C. Information for requesting an external review. Notice of the grievant’s right to request an external review shall include the address and telephone number of the MHCB, a description of all procedures and time deadlines necessary to pursue an external review, copies of all forms required to initiate an external review and the following language:

“We have 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, at no cost to you, by an impartial Independent Review Organization (IRO) who has no association with us and is appointed by the Office of Superintendent of Insurance (OSI). If our decision involved making a judgment as to the medical necessity, the experimental nature or the investigational nature of the requested service, or the appropriateness, health care setting, or level of care, then the IRO review will be performed by one or more health care professionals. You may also request an external review by OSI for rescission or adverse determinations that do not involve medical judgment. For more information contact OSI by electronic mail at mhcb.grievance@state.nm.us; by telephone at (505) 827-4601; or toll-free at 1-(855)-427-5674. You may also visit the OSI website at <http://www.osi.state.nm.us> for more information.”

D. Grievance discontinued. If the grievant informs the health care insurer by telephone that the grievant does not wish to pursue the grievance, the health care insurer’s notice shall include written confirmation of the grievant’s decision not to pursue the matter further.

E. Grievant’s decision unknown. If the health care insurer is unable to contact the grievant by telephone within one day of the panel’s decision to uphold the adverse determination, the health care insurer’s written notice shall include all information necessary to request an external review.

[13.10.17.17 NMAC - Rp, 13.10.17.22 NMAC, 1/1/17]

13.10.17.18 ADDITIONAL REVIEW BY ENTITIES SUBJECT TO THE NEW MEXICO HEALTH CARE PURCHASING ACT:

A. Applicability. This section applies only to entities and grievants subject to the New Mexico Health Care Purchasing Act (public employees and retirees, public school employees and retirees only).

B. Eligibility for review. A grievant who remains dissatisfied with the decision of the health care insurer after the completion of the internal panel review must have their claim reviewed in accordance with any review process established by the entity providing their health care benefits pursuant to the New Mexico Health Care Purchasing Act.

C. Decision to uphold. If the health care insurer has upheld the initial adverse determination to deny the requested health care service at both the first level internal review and the internal panel review, the health care insurer shall notify the grievant that their grievance must be reviewed by their specific review board before their grievance may be eligible for an IRO review, as defined by their policy. The health care insurer shall ascertain whether the grievant wishes to pursue the grievance before the specific review board.

(1) If the grievant does not wish to pursue the grievance, the health care insurer shall include confirmation of the grievant's decision not to pursue the matter further with the written notification of the health care insurer's decision as described in Subsection B of 13.10.17.17 NMAC.

(2) If the health care insurer is unable to contact the grievant by telephone within one day of the panel's decision to uphold the adverse determination, the health care insurer shall send a written inquiry, as described in Subsection D of 13.10.17.17 NMAC.

(3) If the grievant responds affirmatively to the telephone or written inquiry the matter will proceed to a review by the grievant's specific review board, according to the procedures contained in the grievant's policy handbook.

D. Extending the timeframe for review. If the grievant does not make an immediate decision to pursue the grievance, the grievant has requested additional time to supply supporting documents or information, or has asked for postponement, the timeframe shall be extended to include the additional time required by the grievant.

E. Notice following review by the specific review board.

(1) **Certification.** Upon receipt of notice from grievant's specific review board that the requested benefit shall be certified, the health care insurer shall provide coverage in accordance to the review board's decision.

(2) **Adverse determination upheld.** Upon receipt of notice that grievant's specific review board upholds the decision denying certification, then MHCBS shall contact the grievant to determine whether grievant wishes to request an external review. If the MHCBS is unable to contact the grievant by telephone within 24 hours, then MHCBS will attempt to contact the grievant and the provider in writing by mail or electronically on the following day.

[13.10.17.18 NMAC - N, 1/1/17]

13.10.17.19 IRO REVIEW OF AN ADVERSE DETERMINATION:

A. Right to external IRO review. Every grievant who is dissatisfied with an adverse determination following internal review of a grievance that involves medical judgment, including a determination based on medical necessity, appropriateness, health care setting, level of care, effectiveness or that the requested health care service is experimental, investigational or unproven for a particular medical condition may request an external review by an impartial IRO appointed by the superintendent at no cost to the grievant.

B. Exhaustion of internal review process. The superintendent may require the grievant to exhaust any required 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 IRO review.

C. Deemed exhaustion. If exhaustion of internal reviews is required prior to IRO review, exhaustion is unnecessary and the internal reviews 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 review process; or
- (3) the grievant simultaneously requests an expedited internal review and an expedited IRO review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection C of 13.10.17.19 NMAC, the internal review 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 within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal review process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of 13.10.17.19 NMAC, the grievant has the right to re-submit and pursue a request for review 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 review of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

E. IRO fees. The health care insurer against which a request for external review has been filed shall be responsible for paying the fees of the IRO. The health care insurer shall remit payment to the IRO within 30 days after its receipt of the invoice.

(1) The superintendent shall determine the reasonable compensation for IROs and shall publish a schedule of IRO compensation by bulletin.

(2) Upon completion of an external review, the IRO shall submit its invoice directly to the health care insurer.

F. In reaching a decision, the assigned IRO is not bound by any decisions or conclusions reached during the health care insurer's utilization review process or the health care insurer's internal grievance process.

G. Nothing in this rule shall preclude the health care insurer and grievant from resolving the matter prior to completion of the IRO review.

H. A grievant may not file a subsequent request for external review by an IRO involving the same adverse determination for which the grievant has already received an external IRO review under this rule.

[13.10.17.19 NMAC - Rp, 13.10.17.24 NMAC, 1/1/17]

13.10.17.20 QUALIFICATIONS OF IROs AND APPROVAL BY SUPERINTENDENT:

A. Superintendent's list. The superintendent shall compile and maintain a list of approved IROs.

B. IRO Requirements. 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 requirements of this rule; and

(3) have quality assurance mechanisms that ensure that clinical reviewers assigned to

conduct the external review are qualified and impartial physicians or other appropriate health care providers who;

(a) have expertise in the treatment of grievant's medical condition;

(b) hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized medical specialty board in the area(s) appropriate to the subject of the IRO review; and

(c) have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise substantial questions about the clinical reviewer's physical, mental or professional competence or moral character.

(4) have written policies and procedures that ensure:

(a) all reviews are conducted within the timeframe specified by this rule and required notices are provided in a timely manner;

(b) the selection of qualified and impartial physicians or other appropriate health care professionals to act as clinical reviewers based on the requirements of specific cases and that the IRO employs or contracts with an adequate number of clinical reviewers to meet this objective;

(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.

(5) maintain a toll-free telephone service to receive information 24 hours a day, seven days per week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours.

C. Applicants for the IRO list. 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;
- (2) all documentation and information requested on the application, including proof of being accredited by a nationally recognized private accrediting entity;
- (3) any applicable application fee pursuant to § 59A-6-1 (BB); and
- (4) completion of a memorandum of understanding, to be supplied by OSI.

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

E. Conflict of interest by an IRO.

(1) An IRO may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health care insurer, a national, state or local trade association of health care insurers, or a national, state or local trade association of health care providers.

(2) Neither an IRO appointed to conduct the independent review nor any clinical reviewer assigned by an IRO to conduct a review may have a material, professional, familial or financial conflict of interest with:

(a) the health care insurer that is the subject of the IRO review;

(b) an officer, director, manager or management employee of the health care insurer that is the subject of the IRO review;

(c) the health benefits plan;

(d) the plan administrator, plan fiduciaries or plan employees;

(e) the grievant or the grievant's representative;

(f) the grievant's health care provider(s) or the provider's medical group, who is recommending the service or treatment that is the subject of the review;

(g) the health care provider's medical group or independent practice association;

(h) a health care facility where the service would be provided; or

(i) the developer, manufacturer, distributor, or supplier of the principal drug, device, procedure or other service that is the subject of the appeal.

F. Written procedures. An IRO shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this rule.

G. Availability of records. An IRO shall keep and maintain written or electronic records and make available upon request by OSI, any record received or reviewed during an IRO review for a period of six years following the review.

H. IRO's report to OSI. An IRO shall keep and maintain written or electronic records of all IRO reviews it has conducted under this rule and make available to OSI every calendar year on January 15, a report that is organized by health care insurer and which includes:

- (1) the total number of reviews conducted;
- (2) the number of 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 review was sought, as provided in the format required by the superintendent;
- (6) the number of reviews that were terminated as a result of a reconsideration by the health care insurer of its adverse determination after the receipt of additional information from the grievant; and
- (7) any other information the superintendent may request or require.

I. Contracts with health care insurers. Nothing in this rule precludes or shall be interpreted to preclude a health care insurer from contracting with an approved IRO to conduct peer or federal external reviews. [13.10.17.20 NMAC - Rp, 13.10.17.23 NMAC, 1/1/17]

13.10.17.21 INITIATING AN IRO REVIEW OF AN ADVERSE DETERMINATION:

A. Expedited IRO review. If required by the medical exigencies of the case, a grievant or provider may telephonically request an expedited review by an IRO by calling the MHCB at (505) 827-4601 or 1-(855)-427-5674. A signed medical release must also be provided.

B. Standard IRO review. To initiate an IRO review, a grievant must file a written request for an IRO review within four months from receipt of the written notice of the final internal review decision unless extended by the superintendent for good cause shown. The request shall be:

- (1) mailed to the superintendent, 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, attn: managed health care bureau - external review request at (505) 827-4734; or
- (4) completed on-line with an OSI complaint form available at <http://www.osi.state.nm.us/>.

C. Duty to re-direct request. Any request for external review sent to the health care insurer instead of to OSI shall be forwarded to the OSI by the health care insurer within three days after receipt.

D. Documents required to be filed by the grievant. The grievant shall file the request for IRO review on the forms provided to the grievant by the health care insurer, OSI, or an entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, and shall also file:

- (1) a copy of the notice(s) of all prior review decisions; and
 - (2) a fully executed release form authorizing the IRO or the superintendent to obtain any necessary medical records from the health care insurer or any other relevant provider.
- [13.10.17.21 NMAC - Rp, 13.10.17.18 NMAC, 1/1/17]

13.10.17.22 TIMEFRAMES AND PROCESSES FOR IRO REVIEW:

A. Type of IRO review. The IRO shall conduct either a standard or expedited review of the adverse determination, as required by the medical exigencies of the case.

(1) The IRO shall complete an expedited external review and provide notice of its decision to the grievant, the provider, the health care insurer, and the superintendent as required by the medical exigencies of the case as soon as possible, but in no case later than 72 hours after appointment by the superintendent. If notice of the IRO's decision is initially provided by telephone, written notice of the decision shall be provided within 48 hours after the telephone notification.

(2) The IRO shall complete a standard external review and provide written notice of its decision to the grievant, the provider, the health care insurer and the superintendent within 20 days after appointment by the superintendent.

B. Expedited IRO review, timeframe and process.

(1) In cases involving an urgent care claim, the superintendent shall immediately upon receipt of a request for an expedited IRO review send the grievant an acknowledgment that the request has been received and send a copy of the request to the health insurer.

(2) Within 24 hours or the time limit set by the superintendent following receipt of a request for an expedited IRO review from the superintendent, the health care insurer shall complete a preliminary review of the matter to determine whether the request is eligible for IRO review, and shall report immediately to OSI upon completion of the preliminary review, as follows:

(a) the grievant is or was a covered person in the health benefit plan at the time the health care service was requested;

(b) the health care service that is the subject of the request for IRO review reasonably appears to be a covered benefit under the grievant's health benefit plan, but for a determination by the health care insurer that the requested service is not covered because it is experimental, investigational, or not medically necessary; and

(c) the grievant has or is not required to exhaust the health carrier's internal grievance process.

(3) If the request is not complete, the health care insurer shall inform the grievant, provider and the superintendent telephonically and electronically and include in the notice what information or materials are needed to make the request complete.

(4) If the request is not eligible for IRO review, the health care insurer shall inform the grievant, provider and the superintendent telephonically and electronically and include in the notice the reasons for ineligibility and a statement that the health care insurer's determination of ineligibility may be appealed to the superintendent.

(5) MHCB will confirm or obtain from the grievant all information and forms required to process an expedited IRO review, including the signed release form.

(6) Upon receipt of the health care insurer's notice that a request is complete and eligible for

IRO review and the confirmation from MHCB, the superintendent will immediately randomly assign an IRO from the superintendent's list of approved IROs to conduct an expedited review, and shall:

(a) notify the health care insurer of the name of the assigned IRO; and

(b) notify the grievant and the provider of the name of the assigned IRO, that the health care insurer will provide to the IRO all of the documents and information considered in making the adverse determination, and that the grievant and provider may provide additional information.

(7) The superintendent may determine that a request is eligible for an expedited IRO review notwithstanding a health care insurer's initial determination that the request is incomplete or ineligible. In making an eligibility determination, the superintendent's decision shall be made in accordance with the terms of the grievant's health benefit plan.

(8) MHCB will immediately provide to the assigned IRO and to the health care insurer all information and forms obtained from the grievant, including a signed release form.

(9) Within 24 hours from the date of the notice from the superintendent that the IRO has been appointed, the grievant or the provider may also submit additional documentation or information to the IRO; the IRO shall immediately forward any documentation or information received from the grievant to the health care insurer.

(10) Upon receipt of the superintendent's notice that an IRO has been appointed, the health care insurer shall within 24 hours provide to the assigned IRO, any information considered in making the adverse determination, including, but not limited to:

(a) the summary of benefits;

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

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

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

(e) any other documents, records, and information relevant to the adverse determination and the internal review decision(s).

(11) Failure by the health care insurer to provide the documents and information required by this rule within the time specified shall not delay the conduct of the IRO external review. If the health care insurer fails to provide the documents and information within the time specified, the assigned IRO may terminate the review and make a decision to reverse the adverse determination.

C. Standard IRO review, timeframe and process.

(1) Within one day after the date of receipt of a request for an IRO review, the superintendent shall send the grievant an acknowledgment that the request has been received and send a copy of the request to the health insurer.

(2) Within five days following the receipt of the IRO review request from the superintendent, the health insurer shall complete a preliminary review of the request to determine whether the request is eligible for IRO review, as follows:

(a) the grievant is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) the health care service that is the subject of the request for IRO review reasonably appears to be a covered service under the grievant's health benefit plan, but for a determination by the health care insurer that the requested health care service is not covered because it is experimental, investigational, or not medically necessary;

(c) for experimental or investigational adverse determinations, the grievant's treating physician certified, in writing, that one of the following applies:

(i) standard health care services or treatments have not been effective in improving the condition of the grievant;

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

(iii) there is no available standard health care service or treatment covered by the health benefits plan that is more beneficial than the recommended or requested health care service or treatment;

(iv) the health care service or treatment requested is likely to be more

beneficial to the grievant, in the physician's opinion, than any available standard health care services or treatments;
or

(v) the grievant's treating physician, who is licensed, board certified or board eligible 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 or treatment requested is likely to be more beneficial to the grievant than any available standard health care services or treatments.

(d) the grievant has exhausted or is not required to exhaust the health care insurer's internal grievance process; and

(e) the grievant has provided all the information and forms required to process an IRO review, including the signed release form.

(3) Upon completion of the preliminary review, the health care insurer shall notify the superintendent and grievant in writing within one day whether:

(a) the request is complete; and

(b) the request is eligible for IRO review.

(4) If the request:

(a) is not complete, the health care insurer shall inform the grievant and the superintendent in writing and include in the notice what information or material are needed to make the request complete; or

(b) is not eligible for an IRO review, the health care insurer shall inform the grievant and the superintendent in writing and include in the notice the reasons for its ineligibility.

(5) The notice of initial determination shall include a statement informing the grievant that a health care insurer's initial determination of ineligibility for IRO review may be appealed to the superintendent.

(6) The superintendent may determine that a request is eligible for an IRO review notwithstanding a health care insurer's initial determination that the request is ineligible and require that it be referred to an IRO. In making an eligibility determination, the superintendent's decision shall be made in accordance with the terms of the grievant's health benefit plan.

(6) Even after the superintendent assigns a grievance to an IRO for review, the MHCB may attempt to resolve the grievance between the health care insurer and the grievant. If the matter is successfully resolved, OSI will immediately notify the IRO to terminate work.

D. Assignment of IRO by superintendent.

(1) Within one day of receipt of a notice that the health care insurer has determined a request is eligible for an IRO review, the superintendent shall:

(a) randomly assign an IRO from the superintendent's list of approved IROs to conduct the review;

(b) notify the health care insurer of the name of the assigned IRO;

(c) notify the grievant in writing that the request is eligible for an IRO external review, the name of the assigned IRO, and that the health care insurer will provide all of the documents and information considered by the health care insurer in making the adverse determination; and

(d) notify the grievant that the grievant may submit in writing to the assigned IRO within five days following the date of receipt of the notice, any additional information that the IRO shall consider when conducting the review. The IRO is not required to, but may, accept and consider additional information submitted after five days.

(2) If the adverse determination is based on a determination that the requested service is experimental, investigational, or not medically necessary, then the superintendent shall direct the IRO to utilize a panel of appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed.

(3) Within one day after the receipt of the notice of assignment by the superintendent to conduct the external review, the assigned IRO shall select one clinical reviewer or for experimental or investigational adverse determinations, three clinical reviewers to conduct the external review.

(4) Within five days following the notice of the assigned IRO, the health care insurer shall provide to the assigned IRO all documents and any information considered in making the adverse determination, including, but not limited to:

(a) the summary of benefits;

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

- (c) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;
 - (d) uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and
 - (e) any other documents, records, and information relevant to the adverse determination and the internal review decision(s).
- (5) Failure by the health care insurer to provide the documents and information required by this rule within the time specified shall not delay the conduct of the external review. If the health care insurer fails to provide the documents and information within the time specified, the assigned IRO may terminate the review and make a decision to reverse the adverse determination. Within one day after making such a decision, the IRO shall notify the grievant, the provider, the health care insurer, and the superintendent.
- (6) If the grievant provides additional supporting documents or information to the IRO:
- (a) The IRO shall send any information received from grievant to the health care insurer within one day.
 - (b) Upon receipt of such information, the health care insurer may reconsider its adverse determination.
- (7) If, upon such review, the health care insurer reverses its prior decision, it shall within one day provide written notification of its decision to the grievant, the provider, the assigned IRO and the superintendent.
- (a) If the health care insurer reverses its prior decision, the assigned IRO shall terminate its review upon receipt of the notice from the health care insurer.
 - (b) Upon reversing its prior decision, the health care insurer shall approve coverage for the health care service subject to any applicable cost sharing including co-payments, co-insurance and deductible amounts for which the grievant is responsible.
 - (c) The health care insurer shall compensate the IRO according to the published fee schedule whenever the IRO review is terminated prior to completion.
- [13.10.17.22 NMAC - Rp, 13.10.17.27 NMAC, 1/1/17]

13.10.17.23 THE FINAL DECISION OF THE IRO AND GRIEVANT'S RIGHT TO HEARING AFTER FINAL IRO DECISION:

A. Independent decision. In reaching its decision, the IRO is not bound by the prior decision of the health care insurer. In addition to the documents and information provided to the IRO by the health care insurer and the grievant and to the extent such documents are available, each reviewer shall consider the following in reaching its decision:

- (1) the grievant's medical records;
- (2) the attending health care professional's recommendation;
- (3) consulting reports from appropriate health care professionals and other documents submitted by the health care insurer, the grievant, or the treating health care professional;
- (4) the terms of coverage under the applicable health benefit plan to ensure that the IRO's decision is not contrary to the terms of coverage;
- (5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- (6) any applicable clinical review criteria and policies developed and used by the health care insurer; and
- (7) the opinion of the IRO's clinical reviewer(s) after considering the information received.

B. Opinion of clinical reviewer. Each clinical reviewer selected shall provide an opinion to the assigned IRO as to whether the recommended or requested health care service should be covered as follows:

- (1) for a standard external review, each clinical reviewer shall provide a written opinion to the IRO within the time constraints set by this rule;
- (2) for an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the IRO as expeditiously as the covered person's medical condition or circumstances requires. If the opinion is provided orally, each clinical reviewer shall provide a written opinion to the IRO within 48 hours after providing the oral opinion; and
- (3) each clinical reviewer's written opinion shall include the following information:
 - (a) a description of the covered person's medical condition;

(b) whether there is sufficient evidence to demonstrate that the requested health care service is more likely than not to be more beneficial to the covered person than any available standard health care services and that the adverse risks of the requested health care service would not be substantially increased over those of available standard health care services;

(c) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) a description and analysis of any evidence-based standards;

(e) the reviewer's rationale for the opinion; and

(f) whether the recommended or requested health care service has been approved by the federal food and drug administration, if applicable, for the condition.

C. Decision of the IRO. Based upon the opinion of each clinical reviewer, the IRO shall issue notice of its decision in the manner set forth in this rule.

(1) If a majority of clinical reviewers recommend that the requested health care service should be covered, the IRO shall reverse the health care insurer's adverse determination.

(2) If a majority of clinical reviewers recommend that the requested health care service should not be covered, the IRO shall uphold the health care insurer's adverse determination.

D. Content of IRO's notice. Notice of the IRO's decision shall be sent to the grievant, the provider, the health care insurer, and the superintendent and shall include:

(1) a general description of the reason for the request for external review;

(2) the date the IRO was appointed;

(3) the date the review by the IRO was completed;

(4) the principal reason(s) for its decision, including any applicable evidence-based standards that were the basis for the decision;

(5) reference to the evidence or documentation that was considered in reaching the decisions;

(6) the rationale for the decision; and

(7) the written opinion of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for each reviewer's recommendation.

E. Binding decision. The decision of the IRO is binding upon the health care insurer except to the extent that the health care insurer may pursue other remedies under applicable state and federal law. The decision is also binding upon the grievant except to the extent that the grievant may pursue other remedies under applicable state and federal law, including the grievant's right to appeal to the superintendent for a hearing.

(1) 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 an IRO's decision or following an external review by the superintendent that denies the claim or otherwise fails to require such payment or benefits.

(2) Upon receipt of a decision by an IRO reversing an adverse determination, the health care insurer shall approve coverage for the health care service for which the IRO review was conducted, subject to any applicable co-payment, co-insurance and deductible amounts for which the grievant is responsible without 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.

[13.10.17.23 NMAC - Rp, 13.10.17.30 NMAC, 1/1/17]

13.10.17.24 SUPERINTENDENT'S HEARING PROCEDURES FOR ADVERSE DETERMINATIONS:

A. Grievant's rights.

(1) Following the IRO's decision, the MHCB shall notify the grievant that if the grievant is dissatisfied with the IRO's decision, the grievant may request a hearing from the superintendent within 20 days of the IRO decision. MHCB will provide the grievant with all forms necessary to request a hearing by the superintendent.

(2) Any grievant whose adverse determination grievance involved a rescission of coverage or did not involve medical judgment may request a hearing by the superintendent within four months of receiving the health care insurer's internal decision. The health care insurer will provide the grievant will all forms necessary to request a hearing by the superintendent.

B. Review of request for hearing. Upon receipt of a request for a hearing, the superintendent will review the request and may grant a hearing if the following criteria are met:

(1) the grievant has exhausted the internal review process or is not required to exhaust the internal review process and, if applicable, the external IRO review process;

- (2) the grievant has timely requested review by the superintendent;
- (3) the grievant has provided a signed release and all forms and documents required to process the request, and
- (4) the health care service that is the subject of the request reasonably appears to be a covered benefit under the applicable health benefits plan.

C. Request incomplete. If the request for an external hearing is incomplete, MHC staff shall immediately notify the grievant and request that the grievant submit the information required to complete the request for external review within a specified period of time. If the grievant fails to provide the required information within the specified time, the request will be deemed to not meet the criteria prescribed by this rule.

D. Request does not meet criteria. If the request for an external hearing does not meet the criteria prescribed by this rule, MHC 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 hearing and is thereby denied.

E. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by this rule, MHC 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 Section 59A-4-18 NMSA 1978 and this rule has been set to consider the request. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with Section 12-8-10 NMSA 1978.

F. Notice of hearing. For an expedited review, the notice of hearing shall be given to the grievant, the provider and the health care insurer telephonically. For a standard review, notice of the hearing shall be provided telephonically, and in writing by mail or electronically no less than 10 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 parties of their respective rights. The superintendent shall not unreasonably deny a request for postponement of the hearing made by the grievant or the health care insurer. If the grievant wishes to supply supporting documents or information subsequent to the filing of the request for a hearing with the superintendent, the timeframes for the hearing shall be extended up to 90 days from the receipt of the request or until the grievant submits all supporting documents, whichever occurs first.

G. Timeframe for completion of hearing. The superintendent shall complete the review within the following timeframes:

- (1) an expedited review shall be completed no later than 72 hours after receipt of the complete request, or as required by the exigencies of the matter under review; and
- (2) a standard review shall be completed within 45 days after receipt of the complete request.

H. 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.

(1) **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.

(2) **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:

- (a) require the production of additional records, documents and writings relevant to the subject of the grievance;
- (b) exclude any irrelevant, immaterial or unduly repetitious evidence; and
- (c) 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.

(3) **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.

(4) **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.

(5) **Hearing recorded.** The hearing shall be stenographically recorded at OSI's expense.

(6) **Rights of parties.** Both the grievant and the health care insurer have the right to:

(a) 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;

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

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

(d) 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.

(7) **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. New Mexico health care plan representative. If a grievant is insured pursuant to the New Mexico 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.

[13.10.17.24 NMAC - N, 1/1/17]

13.10.17.25 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 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 ICOS.

(1) **Compensation schedule.** The superintendent shall 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 days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOS.

D. Record retention. The hearing officer and ICOS must maintain written records for a period of three years and make them available upon request to the state.

[13.10.17.25 NMAC - Rp, 13.10.17.32 NMAC, 1/1/17]

13.10.17.26 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 within 30 days for a standard review. Any hearing officers may submit a supplementary or dissenting opinion to the recommended decision.

B. Order. Within 10 days after receiving the recommendation of the ICOS, the superintendent will 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 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.
[13.10.17.26 NMAC - Rp, 13.10.17.33 NMAC, 1/1/17]

13.10.17.27 INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES:

A. Request for internal review of administrative decision. Any covered person dissatisfied with an administrative decision, action or inaction of a health care insurer, including termination of coverage, has the right to request internal review of an administrative decision orally or in writing within 180 days after receiving the administrative decision.

B. Acknowledgement of grievance. Within three 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 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.

D. Time for decision. The health care insurer shall mail a written decision to the grievant within 30 days of receipt of the administrative grievance.

E. Contents of notice of decision. The written decision shall contain:

(1) the name, title and qualifications of the person conducting the initial review;

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

(3) a clear and complete explanation of the rationale for the reviewer's decision;

(4) identification of the health benefits plan provisions relied upon in reaching the decision;

(5) reference to evidence or documentation considered by the reviewer in making the decision;

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

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

[13.10.17.27 NMAC - Rp, 13.10.17.35 NMAC, 1/1/17]

13.10.17.28 RECONSIDERATION OF INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Reconsideration committee. Upon receipt of a request for reconsideration, the health care insurer shall appoint a reconsideration committee consisting of two or more representatives of the health care insurer who did not participate in the initial decision and who are authorized to take corrective action on the grievance.

B. Hearing. The reconsideration committee shall schedule and hold a hearing within 15 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 for up to 30 days 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 five days in advance. The notice shall advise the grievant of the rights specified in Subsection E of 13.10.17.28 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 at grievant's own expense.

D. Information to grievant. No fewer than three days prior to the hearing, the health care insurer shall provide to the grievant all documents and information that the reconsideration 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 the grievant's case to the reconsideration committee;
- (3) submit supporting material both before and at the reconsideration committee hearing;
- (4) ask questions of any reconsideration committee member; and
- (5) be assisted or represented by a person of their choice.

[13.10.17.28 NMAC - Rp, 13.10.17.36 NMAC, 1/1/17]

13.10.17.29 DECISION OF RECONSIDERATION COMMITTEE:

A. Committee Decision.

(1) **Denial of payment of post-service claim in whole or in part.** If the initial administrative decision involved a failure to make payment in whole or in part for a post-service claim for a covered benefit, the reconsideration committee shall review the claim to determine whether the claim was paid in accordance with the terms of the health benefits plan.

(2) **Rescission.** If the initial administrative decision involved rescission, the reconsideration committee shall review the request to determine whether the grievant or a person seeking coverage on behalf of the grievant performed an act, practice or omission that constitutes fraud, or made an intentional misrepresentation of material fact, as prohibited by the terms of the health benefits plan.

B. Written decision. The health care insurer shall mail a written decision to the grievant within seven days after the reconsideration committee hearing.

C. Contents. The written decision shall include:

- (1) the names, titles and qualifications of the persons on the reconsideration committee;
- (2) the reconsideration committee's statement of the issues involved in the administrative grievance;
- (3) a clear and complete explanation of the rationale for the reconsideration committee's decision;
- (4) the health benefits plan provision(s) relied on in reaching the decision;
- (5) references to the evidence or documentation relied on in reaching the decision;
- (6) a statement that the initial decision will be binding unless the grievant submits a request for external review by the superintendent within 20 days after receipt of the reconsideration decision;
- (7) if applicable, notice of the grievant's right to request review from and in the manner designated by the entity that is providing the health benefits plan to the grievant pursuant to the New Mexico Health Care Purchasing Act; and
- (8) 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.

[13.10.17.29 NMAC - Rp, 13.10.17.37 NMAC, 1/1/17]

13.10.17.30 EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES BY SUPERINTENDENT:

A. Right to external review and scope. Every grievant who is dissatisfied with the results of the internal review and reconsideration committee hearing 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 an 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 reviews is required prior to external review, exhaustion must be unnecessary and the internal reviews process will be deemed exhausted if:

- (1) the health care insurer waives the exhaustion requirement; or
- (2) the health care insurer is considered to have exhausted the internal reviews process by failing to comply with the requirements of the internal reviews process.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection C of 13.10.17.30 NMAC, the internal claims and reviews 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 reviews process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of 13.10.17.30 NMAC, the grievant has the right to re-submit and pursue the internal review 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 review of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

[13.10.17.30 NMAC - Rp, 13.10.17.38 NMAC, 1/1/17]

13.10.17.31 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 days after receipt of the written notice of the reconsideration committee's decision. The grievant shall file the request for external review on the forms provided by the health care insurer, and submitted as follows:

- (1) mailed to the superintendent, 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;
- (2) e-mailed to mhcb.grievance@state.nm.us, subject: external review request;
- (3) faxed to the superintendent, attn: managed health care bureau - external review request at (505) 827-4734; or
- (4) completed on-line using an OSI complaint form available on website of the OSI.

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

C. Extending timeframes for external review. If 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.

[13.10.17.31 NMAC - Rp, 13.10.17.39 NMAC, 1/1/17]

13.10.17.32 ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE BY SUPERINTEDENT:

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

- (1) the grievant an acknowledgment that the request has been received; and
- (2) the health care insurer a copy of the request for external review along with all documents submitted by or on behalf of the grievant with the request.

B. Items provided by health care insurer. 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 days all necessary documents and information considered in arriving at the administrative grievance decision and reconsideration committee's decision. The health care insurer may also provide any documents or information it determines are necessary to respond to additional documents or information that have been provided by or on behalf of the grievant.

[13.10.17.32 NMAC - Rp, 13.10.17.40 NMAC, 1/1/17]

13.10.17.33 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, and the health care insurer, as appropriate. The superintendent shall issue a written decision on the administrative grievance within 45 days after receipt of the complete request for external review.

[13.10.17.33 NMAC - Rp, 13.10.17.41 NMAC, 1/1/17]

13.10.17.34 CONFIDENTIALITY OF A GRIEVANT'S RECORDS AND MEDICAL INFORMATION:

A. Confidentiality. Health care insurers, the superintendent, ICOs, IROs and their reviewers, 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, IROs, and health care insurers shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of grievants that are submitted as part of any grievance.

[13.10.17.34 NMAC - Rp, 13.10.17.11 NMAC, 1/1/17]

13.10.17.35 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 covered person for whom the grievance was made;
- (5) identify by name and member number the covered person 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. Health care insurers shall annually submit to the superintendent a compilation of data extracted from the grievance register on or before March 1. The specific data to be submitted will be listed in the MHCB's section of the website of the OSI.

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 to state or federal agency officials subject to any applicable federal or state patient confidentiality laws regarding disclosure of personally identifiable health information.

[13.10.17.34 NMAC - Rp, 13.10.17.12 NMAC, 1/1/17]

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 5/3/2004.

13.10.17 NMAC, Grievance Procedures, effective 1/1/2016.

13.10.17 NMAC, Grievance Procedures, effective 1/1/2017.

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 5/3/2004.
13.10.17 NMAC, Grievance Procedures, filed 3/12/2004 - Repealed effective 1/1/2016.
13.10.17 NMAC, Grievance Procedures, filed 11/17/2015 - Repealed effective 1/1/2017.