This is an amendment to 13.10.17 NMAC, sections 1, 2, 3, 7, 9, 10, 15, 17, 18, 19, 21, 22, 23, 24, 31 and 33 effective 11/19/2024.

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, 1/1/2017; A, 11/19/2024]

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, limited scope vision care, limited scope dental 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, 1/1/2017; A, 11/19/2024]

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~~] 59A-57-1 through 59A-57-11 NMSA 1978.
[13.10.17.3 NMAC - Rp, 13.10.17.3 NMAC, 1/1/2017; A, 11/19/2024]

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 ten 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 ten 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~~] one to five days means only working days and excludes weekends and state holidays; and

(2) [~~6~~] six 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 or ICO" means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in 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. "Limited Scope dental or limited scope vision" means any vision or dental care plan as that term is defined under Section 59A-23G-2 NMSA 1978.

AA. "Managed health care bureau or **MHCB"** means the managed health care bureau within the office of the superintendent of insurance.

[~~**AA**~~] **BB. "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**~~] **CC. "Office of the superintendent of insurance or OSI"** means the office of the superintendent of insurance or [~~its~~] staff of the office of superintendent of insurance.

[~~**CC**~~] **DD. "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**~~] **EE. "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**~~] **FF. "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**~~] **GG. "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**~~] **HH. "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**~~] **II. "Retrospective review"** means utilization review that is not conducted prior to provision of health care services.

[~~II~~] **JJ.** **"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~~] **KK.** **"Superintendent"** means the superintendent of insurance, or the office of the superintendent of insurance.

[~~KK~~] **LL.** **"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~~] **MM.** **"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~~] **NN.** **"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~~] **OO.** **"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~~] **PP.** **"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, 1/1/2017; A, 11/19/2024]

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 the grievant that the MHCB is also available for assistance with appropriate forms and deadlines.

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, 1/1/2017; A, 11/19/2024]

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) notify the covered person that the MHCB may only provide limited guidance regarding appropriate forms and deadlines but the MHCB does not act as a covered person's representative;

[~~**(4)**~~] **(5)** 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)**~~] **(6)** provide notice to covered person in a culturally and linguistically appropriate manner as defined in Subsection H of 13.10.17.7 NMAC;

[~~**(6)**~~] **(7)** provide continued coverage for an approved on-going course of treatment pending the final determination on review;

[~~**(7)**~~] **(8)** 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)**~~] **(9)** 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, 1/1/2017; A, 11/19/2024]

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~~] 15 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~~] Independent Review Organization (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~~] mhcb.grievance@osi.nm.gov; 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, 1/1/2017; A, 11/19/2024]

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 through OSI;

(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~~] Independent Review Organization (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~~] mhcb.grievance@osi.nm.gov; 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, 1/1/2017; A, 11/19/2024]

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 external review through OSI including 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 MHCB shall contact the grievant to determine whether grievant wishes to request an external review. If the MHCB is unable to contact the grievant by telephone within 24 hours, then MHCB 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, 1/1/2017; A, 11/19/2024]

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~~] the 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, 1/1/2017; A, 11/19/2024]

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 complaint form with signed medical release must also be provided. Request for expedited external review filed with the OSI must include a statement from the grievant's treating physician.

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:~~] attention: 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~~] mhcb.grievance@osi.nm.gov, subject: external review request; or

(3) faxed to the superintendent, [~~attn:~~] attention: managed health care bureau - external review request at [~~(505) 827-4734~~] (505) 827-4253; 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. Requests for expedited review should be forwarded to OSI as required by the medical exigencies of the case.

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, 1/1/2017; A, 11/19/2024]

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.~~] up to three clinical reviewers.

(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, 1/1/2017; A, 11/19/2024]

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~~] the clinical [~~reviewer~~] reviewers, 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, 1/1/2017; A, 11/19/2024]

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, MHCB 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, MHCB 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, MHCB 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 in addition, also designate two [~~ICOs~~] independent co-hearing officers (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, dismiss the matter for good cause 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, 1/1/2017; A, 11/19/2024]

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.~~] attention: 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~~] mhcb.grievance@osi.nm.gov, subject: external review request;

(3) faxed to the superintendent, [~~attn.~~] attention: managed health care bureau - external review request at [~~(505) 827-4734~~] (505) 827-4253; 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, 1/1/2017; A, 11/19/2024]

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~~] 60 days after receipt of the complete request for external review.

[13.10.17.33 NMAC - Rp, 13.10.17.41 NMAC, 1/1/2017; A, 11/19/2024]